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THE CANADIAN NURSE

L'Infirmière canadienne

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Between Ourselves

During the "Nursing in the News" panel discussion at the biennial convention, a question was asked regarding the lapse of time that occurs so frequently between the date that an article is accepted for publication and the issue in which it eventually appears in print. It is reasonable that this question should be raised now and then. The authors forget that there is only room for some eight or ten articles of any length, even in the 104-page issues we have been running lately.

In an attempt to throw some light on this matter, we have prepared this month's editorial in the form of **two letters** — one from an imaginary "E.M." and the editor's reply to her. We hope that this explanation will be read by those nurses who have shown their interest in their own professional *Journal* by writing for it — and who, alas, sometimes grouch about the almost inevitable delay. Last April, for instance, we acknowledged thirteen articles, four came in May, six in June, five in July.

It is wonderful to have this backlog of material available. Please keep it coming. But be patient with us when publication is slow.

* * *

The last two of the addresses given at the convention that we shall be publishing are included in this number. The title that **Dr. W. S. Stanbury** chose for the Mary Agnes Snively Memorial Lecture, "Our Common Heritage," reflects the very important role of nurses in the operation of the Canadian Red Cross Society. Though the active membership of the C.R.C.S. includes thousands of non-professional workers, in the event of an emergency or a disaster, the burden of responsibility falls on the professional group. It is well, therefore, that we as nurses should be thoroughly familiar with the guiding principles of that great voluntary organization, the Red Cross.

* * *

One of the accomplishments of an able speaker is the ability to hold the audience in rapt, almost breathless attention. Occasionally, when the same address appears in black and white it has lost some of the sparkle and interest the personality of the speaker gave it. Those of us who have been held in thrall as **Helen G. McArthur** weaves her magic with words have long since learned that the published address will carry the imprint of her personality with it. It will be good reading. The truth of this comment is fully borne out in the address she delivered to the students in Ottawa last June. Because only about 2500 of the students in schools of nursing across Canada are on our mailing list to receive their personal copies, we hope that graduates will share this October issue with those other students so that all may read Miss McArthur's message to them.

* * *

By now, most graduates in Canada are aware of the fact that the convention body approved a **retirement plan** that is available to every active member of the Canadian Nurses' Association. While brief mention of this new arrangement was made in the story of the convention in the August issue, a description of the plan is included here. Booklets outlining the various methods by which nurses may be enrolled are in process of being mailed out. You may already have received your copy. Study them carefully. If you have some questions that are not answered, do not hesitate to write to the National Life Assurance Company for your answers. Plenty of questions were asked from the floor at the convention. Above all, seriously consider the importance of building a nest-egg of your own against the time ten, twenty, thirty, forty years from now when a retirement income that you have provided for yourself may make the difference between comfortable living and just scratching along.

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Edited by DEAN F. N. HUGHES

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Indications—An anti-inflammatory, anti-infective ointment for use in the eye — conjunctivitis and keratitis; and in the ear — inflammations of the external auditory canal, and acute and chronic otitis media.

Not to be used in ocular tuberculosis.

Administration—Small quantities to be applied under the eyelid, or in the ear 3 or 4 times daily.

FLEXILON-HC

Manufacturer—McNeil Laboratories of Canada Ltd., Toronto.

Description—Each enteric-coated pink tablet contains: Flexin (zoxazolamine) 125 mg., tylenol (acetaminophen) 300 mg., hydrocortisone 2.5 mg.

Indications—As a muscle relaxant, analgesic and anti-inflammatory agent in a variety of orthopedic and rheumatic disorders.

Administration—Dosage should be individualized. Start with one tablet 3 or 4 times a day with food. May be increased to 2 tablets 3 or 4 times a day. Additional steroid may be administered at the physician's discretion.

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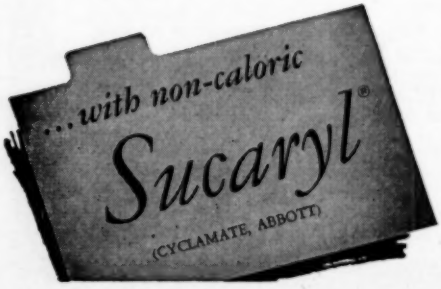

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L'Infirmière canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 54 NUMBER 10

MONTREAL, OCTOBER 1958

Meeting the Deadline

Dear Editor:

I have just finished reading my August and September copies of the *Journal* and I felt that I must tell you how much I have enjoyed them. Since I was not one of the fortunate delegates making up the 2,356 attending the Convention, it has been wonderful to have the reports and the addresses appear in print.

What a wonderful time you must have had. How I would have loved to have seen Cavalcade in White! However, I am beginning to plan now for Halifax, 1960.

There is one other little matter on my mind. Quite some time ago, in January to be exact, I sent along a nursing care study on one of my patients who had had particularly successful treatment for cancer.

You very kindly accepted it but so far I have not seen it in print. After reading those convention addresses, I realize that my literary efforts must seem rather inadequate. I still have this urge to express myself on paper once in awhile. If you would suggest suitable topics and advise me about the length of the article and the way it should be approached, I should like to try again.

I am a general duty nurse on a large surgical floor. Just at the moment we are experimenting with a TV circuit on the ward to see how it affects closer supervision of our patients. As an older graduate I am somewhat skeptical — but I am trying to keep an open mind.

I am looking forward with interest to your reply.

Yours sincerely
E. M.

Dear Miss M———:

I was delighted to have your comments on the August and September issues. Perhaps you do not realize it but letters such as yours perform a real service for the staff of your *Journal*. It is one of the few ways that we have of finding out whether or not our subscribers are satisfied. I wish more of them would write us even if the results are less complimentary than your remarks.

Yes, it *was* a wonderful convention. Even the weather cooperated. I am glad that you have been able to capture a bit of the thrill from our reports and the addresses. But there is nothing like being a part of such a meeting — so just keep Halifax, 1960 in mind.

Now, about your article. It was filed in our office on January 15 and our letter of acceptance was mailed the same day. Contrary to your feeling that it, perhaps, did not measure up too well as acceptable editorial material, I considered it an excellent study. The time lag in publication can, very understandably, be disappointing, so let me explain why it is one of the necessary evils in producing a magazine such as ours.

When your letter and article arrived on January 15, we had already done considerable planning for the next 12 months. As a matter of fact the January issue was on its way to the subscribers — you included; the material for the February issue had started to come back from the printers for proofreading; the editorial material for March had been planned and was being typed for the printers and we knew pretty well what would be in the April issue — the articles for it were in the process of being edited. To go on, we even knew what would be in the *July* issue since it is becoming somewhat of a tradition to publish the patient care studies of the successful students in the Macmillan Award competition. This usually takes up every available line of space that we have for major editorial material in that month.

June was our special anniversary issue honoring the CNA. I hope you enjoyed that number. We are especially proud of it! You will remember, too, that to provide space for our distinguished authors we printed very little else except their articles. You have already commented upon the August and September numbers. Somehow, I do not think you would have been as pleased if the convention addresses had appeared in the December issue!

I can almost hear you saying "Well, why not print a larger edition of the *Journal*?" The answer is very simple. It is for the very same reason that you decided that last summer's hat would do for this year — the budget simply would not stretch any further.

Let us look ahead now. You will not be disappointed again when you see the November issue. Your article will be there and you will discover something special about it. By waiting until then for publication, it will have gained in significance and practical value since we will be incorporating it into an issue devoted almost entirely to cancer and its treatment. Incidentally we have had the balance of the material for that issue on hand almost as long as we have had your article.

I hope that this has explained the situation. True, this was rather a special year — but then every year has its quota of special events, and we must arrange our publication of material accordingly.

You asked for suggestions for the future. My best advice to you or to any other contributor is simply to look around you, see what is happening in your *own* field that you could share with others — and then let us know about it. Be sure your facts are accurate, sufficiently detailed to be useful to others and that they have been cleared by the necessary authorities in your situation if this seems to be called for. Just for a start — what about this experiment in the use of a ward TV circuit? That is certainly a new development that would be of interest to many people in the nursing service field. Let us hear about it as soon as you have some facts on its usefulness.

By the way, it is ages since we have had any news items from your hospital or the alumnae association. You know, we asked the nurses attending the Convention if they really wanted us to continue this section or not. Some did not, but the majority said "yes" most emphatically. Do you think you could help to find one of your nurses willing to take on the job of submitting news about your hospital and graduates regularly — preferably every month? How about volunteering for the job yourself?

Oh, yes — I have also put your name down on our list of possible book reviewers. We have many excellent texts on general surgical nursing come to us for review and I think you would enjoy doing a review. Besides, you get the book as a reward!

The printer has just called — will we *please* send down more copy. So, on a bright, warm September day, here I am planning our Christmas number.

Yours sincerely,

The Editor.

Our Common Heritage

W. Stuart Stanbury, M.B.E., B.A., M.D.

It is a special pleasure for me to deliver the Mary Agnes Snively Memorial Lecture in this your 50th Anniversary year, as the coming of age of the nursing profession and the Red Cross in Canada were almost simultaneous. During the years when Canadian nurses were battling for recognition as a professional group, a small band of volunteers under the leadership of Major General George Sterling Ryerson was struggling to establish the Red Cross movement in Canada as the first colonial branch of the British Red Cross Society. In 1908, Miss Snively succeeded in forming the Canadian National Association of Trained Nurses and in the following year the Government of Canada granted an Act of Incorporation to the Canadian Red Cross Society.

In the intervening half century, our two organizations were inextricably bound together by common ideals and aims. Red Cross did much to strengthen and support the work of the nursing profession. Members of the nursing profession have been and are an integral part of the Red Cross movement.

Speaking of tradition in one of his essays on poetry, T. S. Eliot said:

> It cannot be inherited, and if you want it you must obtain it by great labor . . . What is to be insisted upon is that the poet must develop or procure the consciousness of the past and that he should continue to develop this consciousness throughout his career.

A society without a rich heritage of cultural, scientific and humanitarian achievement is a barren one. The theme of your conference has been the challenge of Florence Nightingale: "Into the future — open a better way." Tonight, I am asking you to honor with me our heritage from the past, a heritage which has made the present possible and will help to open the way for a better future.

Next year, we shall celebrate the Centennial of the birth of the Red Cross idea in the mind of its founder, Henri Dunant. In this, you, as members of the Canadian Nurses' Association, will share in your own right. Just as Florence Nightingale and Scutari represent the recognition of the value of professional nursing to armies in the field, so are Henri Dunant and the Battle of Solferino synonymous with the Geneva Conventions and the protection of medical and nursing personnel in times of war. Nowhere have I found a finer and more moving elucidation of our common heritage than in *Red Cross Principles,* as recently defined by Dr. Jean S. Pictet, Director for General Affairs of the International Committee of the Red Cross.

According to Dr. Pictet, our doctrine can be described in seven "Fundamental Principles" which inspire the Red Cross and influence its actions, and ten "Organic Principles," which guide the practical application of doctrine. I do not propose to speak of the Principles in any particular order, nor to distinguish between the Fundamental and Organic Principles, but shall use them in the most convenient form. Of necessity, I shall quote Dr. Pictet's own words so freely that it is impossible to give due credit in this case.

Auxiliary Status:

While not directly applicable to the Canadian Nurses' Association, the principle of auxiliary status as related to the Canadian Red Cross Society establishes our early mutual interests.

The National Red Cross Societies were created in the first instance for the sole purpose of being auxiliaries to the Army Medical Services. It is an absolute condition of recognition by the International Committee that a National Society shall have been so acknowledged by its own government. Hence the first purpose of the Canadian Red Cross Society, as cited in its Charter is, "to furnish volunteer aid

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Dr. Stanbury, who is National Commissioner of the Canadian Red Cross Society, prepared this material for delivery to the Canadian Nurses' Association on June 27, 1958.

to the sick and wounded of armies in time of war."

As late as World War I, the Canadian Red Cross Society, and in fact Red Cross throughout the world, was mainly restricted to war service activities. The part played by Canada's nursing sisters overseas in World War I is a glowing page in her history. The first contingent of Canadian Red Cross nurses did not go overseas until 1915, but from the onset of hostilities and throughout the war the Society was performing other facets of its traditional role. A postwar report pays tribute to the skilled cooperation of graduate nurses across the country and particularly to Miss Jean I. Gunn, Lady Superintendent of the Toronto General Hospital, for her invaluable assistance in the standardization of surgical supplies. Our greatest contribution to the war effort was the establishment of seven hospitals in England and France and a convalescent rest home for Canadian nurses in England.

In 1930, the Canadian Nurses' Association and the Candian Red Cross Society launched a plan of enrolling registered nurses for emergency service in both war and disaster. By September, 1939, 4,080 nurses were enrolled by the Joint Committee and this list was kept in constant revision until September, 1943, when the committee was dissolved. It was felt that the original objective had been achieved, namely, recognition of basic standards for the selection of nursing personnel for service with the Armed Forces and for disaster.

Foresight:

There is no doubt that the principle of Foresight carries implications in many lines of endeavor but you and we, in particular, must always be ready for the tasks with which we are faced.

Although originally established as an auxiliary to the Army Medical Services, it was gradually recognized, and expounded by the League of Nations, that Red Cross could also be of assistance to the public authorities in peacetime, particularly in the medical, nursing and public health fields. After World War I, therefore, the League of Red Cross Societies came into being for the express purpose of giving leadership and guidance to the National Societies and consolidating their peacetime efforts. It is interesting to note that the Canadian Red Cross Society Act, assented to in 1909, restricted the activities of the Society to times of war. It was not until the Act was amended in 1919, in conformity with Article 25 of the Convenant of the League of Nations, that the Government of Canada granted authorization: "in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world," and so tied our future together at all times.

Recognizing the need for public health nurses with some special preparation, and as a tribute to nursing services during the war, one of the first acts of our Society under its extended mandate was to finance courses in public health nursing in five universities across the country. In addition, in some provinces we engaged public health nurses to work in rural districts under the supervision of the provincial Departments of Health for limited periods.

Our tribute to the nurses of World War II was to sponsor and heavily subsidize the Demonstration School of Nursing in Windsor, Ontario, the first attempt to create a new pattern of nursing education along sound educational lines, as opposed to the so-called apprenticeship system of in-service training and incidentally to reduce the nursing course from three to two years.

Our Nursing Services Committee, drawn from among your most distinguished members, is conscious that one of the concerns of your Association is inadequacy of bursary facilities to enable qualified nurses to pursue advanced studies in the specialized fields of nursing. For some years, we have had a small annual budget to provide bursaries for our own staff who wish to return to university, and latterly, a bursary is available to the nursing profession as a whole in preparation for nursing research.

It is one of our basic philosophies that assistance, to be effective, must have a solid groundwork of preparation. The provision of instruction in First Aid and Home Nursing, the initiation of the Sickroom Supply Loan Service in communities across the

country, were all efforts to prepare ourselves and the Canadian people for tasks which would surely arise.

Our By-laws enjoin us to cooperate with other nationally organized and voluntary bodies performing work within Red Cross Principles. In line with this policy, an agreement between the St. John Ambulance and us has been designed to prevent any possible duplication in facilities for teaching First Aid and Home Nursing. As the two recognized training agencies for Civil Defence Home Nursing auxiliaries and with the assistance of volunteer professional nurses, an important role in Civil Defence is presently being fulfilled. One of our most impressive Home Nursing statistics in 1957 was the 28,488 hours of volunteer instruction given by registered nurses, for which we are profoundly grateful and we know that the St. John Ambulance can report a similar response.

The advent of a national hospitalization plan makes the strengthening of resources in the home even more urgent and important. Ever mindful of the necessity for foresight, therefore, our National Nursing Committee has arranged for Dr. Kathleen Russell, Professor Emeritus of the School of Nursing, University of Toronto, and our former Honorary Adviser in Nursing, to undertake a study into resources available for nursing and related services in the home.

Unity:

Due Proportion:

Under the Principle which he delineates as "Unity," Dr. Pictet reminds us that a National Society must be the only one of its kind; its action must embrace the whole territory; it must be centrally controlled and it can be represented in the international world only by its central body. To the public there is only one Red Cross; success or failure on the part of each unit to live up to our Principles affects the whole body.

Only through a strong and unified organization can we ensure that the entire resources of the Society can be mobilized, quickly and efficiently, in case of national emergency. "Due Proportion" reminds us that assistance should be given on a basis of need, not loss, and that equal service must match an equal degree of distress.

Like most of our other Principles, "Unity" and "Due Proportion" are unwritten principles of the nursing profession in Canada. Your licensing bodies are provincial, but it is only through a central organization like the Canadian Nurses' Association that you have been able to establish and maintain high professional standards throughout the country, to be recognized internationally and, through your international channels, to contribute to the training and welfare of your colleagues in other countries. The nurse, in her daily work, is constantly faced with the problem of living up to the ideal of "Due Proportion." The patient who receives the first service, and the greatest degree of service, must be the patient whose need is the most urgent, and to this principle the nurse must sublimate all her natural emotions of friendship or bias.

Dr. Margaret Mead, internationally known anthropologist and author, has expressed the place of the nurse in the community as:

> You stand between all those who are vulnerable and the possibility that the community may forget them, may not care for them . . . and there is no possibility of a human society where this will not always exist.

Universality:

Equality:

Solidarity:

Service must extend to all men and all countries. We must be ready to come to the help of each individual, equally and without any form of discrimination. Solidarity is established through mutual relationships between countries which recognize that it is their duty to help one another. These are principles which, without doubt, are common to us both.

"Red Cross," Dr. Pictet tells us, "has achieved in practice the universality which the most advanced civilizations, and even religions, have conceived but not been able to attain." To Red Cross, the people of the world are divided into those who are fortunate enough to be able to give help and those who need help. The 80 National Societies are separate entities but they have all met the same conditions of recognition by the International Committee and the League. They have established mutual relationships and

recognize that it is their duty to help one another.

To help a sister Society can and does mean that one helps the Society itself — by the provision of technical and educational materials, through study visits of officers and staff to more highly developed countries and in many other ways. It has been our privilege to welcome nurses from many parts of the world. More frequently, help takes the form of material assistance to enable a sister Society to care for its own people in times of natural or man-made disaster. One of the inflexible rules of international relief in the Red Cross world is that assistance must be channeled through either the National Society of the recipient country or the International Red Cross, in order to ensure freedom from discrimination in any form. You, as nurses, would have broken the pledge you made at your graduation if you gave a higher standard of service to one patient than to another who was equally ill. We, as trustees of Red Cross, are adamant that the needy shall be categorized according to degree of need only.

Autonomy:
Equality of the National Societies:

Red Cross is at the same time a private organization and a public service. One of the conditions for recognition of a National Society, which governments themselves have sanctioned under the Geneva Conventions, is that it "must be free to operate in conformity with the Fundamental Principles of Red Cross." When it serves as a channel through which its government distributes relief in foreign countries, it must be careful never to become an instrument for establishing political influence. This has never been a problem in Canada where our government recognizes that we accept designated funds with the stipulation that they will be administered in accordance with Red Cross principles, that is, distribution will be effected through the national Society of the country concerned or the International Red Cross on the basis of need only.

In both national and international spheres we, like the nursing profession, have a policy of equal rights for all components, taking no account of strength or weakness, to avoid the danger of introducing politics or of a struggle for undue influence.

Multitudinism:

One of the articles of the "International Code of Nursing Ethics" states:

> Professional nursing service is unrestricted by consideration of nationality, race, creed, color, politics or social status.

This is almost identical to one of the conditions for recognition of a National Red Cross Society, namely, that it "shall not withhold membership from any of its nationals, whoever they may be, on grounds of race, sex, class, religion or political opinions." We frequently remind our branches that this statement might be transposed into a more positive form by saying that a National Society should recruit as many members as possible, on the widest basis, without any form of discrimination, not forgetting to include the foreign-born who are making new homes in our midst. Both you and we must be constantly vigilant to uphold this tenet so that Canada may be an example to those countries of the world where this principle is sometimes forgotten or ignored.

Independence:
Selflessness:

As is true of the International Council of Nurses, if Red Cross is to remain the Red Cross, it must be master of its own decisions; it must control its own actions and words. It must be free to base its actions on purely humanitarian motives, free to remain universal. In a country such as Canada, the likelihood of undue political or religious influence is negligible, but we must also protect our economic independence. Red Cross cannot be incorporated in or associated with another institution which does not fully respect its spiritual and material independence. In spite of the fact that its livelihood is contingent on public support, it must refuse any financial contribution which would affect its independence to even a very slight extent.

In times of peace, it is sometimes difficult for persons not actively associated with Red Cross to fully appreciate why our independence must be so rigidly guarded. They tend to forget that the Red Cross emblem is more than a trademark of a charitable organization. It is also, and primarily,

the symbol of the greatest and most widely respected code of international law the world has ever known. If the emblem is not, in times of peace, restricted to the principles and uses enunciated in the Geneva Conventions and resolutions of the International Red Cross Conferences, it will cease to be respected in times of war and internal conflict.

During the revolt in Hungary, many charitable organizations, both religious and lay, provided generous quantities of relief supplies for the Hungarian people, but only the International Committee of the Red Cross — the traditionally neutral body composed entirely of Swiss citizens — was given permission by the Hungarian and Soviet Governments to accompany medical and relief supplies into Hungary and supervise their distribution. In times of war, the emblem gives nursing and medical personnel of the Armed Forces the right to the respect and protection of the civil and military authorities of all belligerents, but it also imposes on them the duty of caring for all wounded and sick, both friend and foe, with the same solicitude, reasons of medical urgency alone justifying priority in any particular case.

Voluntary Service:

As Mr. Jean J. Lossier has expressed it:

> To serve means to give, to sacrifice part of oneself, part of what one is, of what one has, on behalf of others.

The Canadian Red Cross Society is classified as a "voluntary agency" and, in spite of a fairly large professional and technical staff, the major portion of our work is still performed by our hundreds of thousands of volunteers — our officers, committee chairmen and members, campaign canvassers, Junior Red Cross teacher-directors, members of the Canadian Red Cross Corps, instructors in Home Nursing, First Aid and Water Safety, women who sew and knit for the Women's Work Committee, blood donors and the countless others who serve quietly and unobstrusively on individual projects.

In Canada, we tend to speak of a volunteer in terms of one who is unpaid for his services. Dr. Pictet points out, however, that "voluntary" does not necessarily mean that one works without remuneration but rather that one is working of his own free will, and will freely adhere to the task he has undertaken, no matter how difficult or dangerous. There are few jobs in Red Cross where it is possible to keep business hours and no "overtime" is paid. It is a credit to Canadians, that so many men and women continue to work for the Society, in spite of the many practical disadvantages.

There are no truer volunteers, in Dr. Pictet's sense of the word, than our nursing staff, the majority of whom are employed either in the Blood Transfusion Service, involving as it does attendance at evening and mobile clinics, or in outpost hospitals. Outpost nursing demands a great deal, both personally and professionally, without the compensations which life in a city hospital can offer, particularly to the younger nurses. As one of our chairman has expressed it:

> Against a serious background of shortage of nurses we have to offer positions of social and professional isolation, calling for unusual demands on time and oftimes hazardous visits at distances from our outposts. Our positions call for self-reliance and ability to carry the Red Cross flag into our frontiers.

Last year, a foreign visitor, impressed by the high standard of outposts in remote sections of Ontario, asked what salary bonus was paid to attract nurses from city hospitals. It gave us much pleasure to be able to reply that our outpost nurses had that rare combination of attributes: dedication to an ideal of service and vision to weigh the value of professional experience under pioneer conditions against the more comfortable but much more circumscribed life of a ward nurse in a city hospital.

International recognition was paid last year to our National Director of Nursing Services and one of your Past Presidents, Miss Helen G. McArthur, who was awarded the Florence Nightingale Medal, one of the highest decorations in the nursing field. I am sure that the International Committee, in making this award, was more than a little influenced by Miss McArthur's eighteen months' service as delegate of the League of Red Cross Societies in Korea. Living and working under far from ideal conditions, she was able to assist not only in rebuilding the

Korean Red Cross Society but also in raising the status of nurses, and in fact of all Korean women, struggling to make a contribution to the public welfare of their country.

Free Service:

This Principle does not mean that the Red Cross must refuse to receive payment. It is, throughout the world, constantly extending its services and meeting emergency situations, with the result that receipts never balance expenditures. It must not, however, make its services contingent on receiving payment as this would be equivalent to refusing help to those who are not in a position to pay.

Nor is there any reason why a government should not reimburse us for expenditures resulting from special tasks undertaken. We had two excellent examples of this principle in connection with Hungarian refugees last year.

At the special request of the Department of Immigration, we provided nursing services for all camps in The Netherlands housing Hungarian refugees destined for Canada, the expense being borne by the Government of Canada. Much comfort and reassurance was brought to these lonely and homesick people by our nurses who, through all the hazards and inconveniences of living and working in refugee camps, represented Canadian nursing in a manner in which we can all take pride.

The government of Ontario invited our local Division to accept administrative responsibility for its reception centres in Toronto, the government undertaking to bear the expenses involved. It would be impossible to express sufficient appreciation for the services freely and generously given in these, and other reception centres across Canada, by registered nurses and the nursing aides trained by them. The person who reported from Ottawa expressed the spirit which animated the volunteers across the country when she wrote:

> The graduate nurses and our Volunteer Nursing Services aides gave cheerfully and freely of their time and energy, but felt well repaid when the suffering refugees made every attempt to express their gratitude.

Humanity:

Neutrality:

Impartiality:

I have left till the last, three of the Fundamental Principles, which were basic to the deliberations of two great international conferences last year: Humanity which fights against suffering and death, which demands that man shall be treated humanely under all circumstances; Neutrality demanding observance of strict neutrality in the military, political, denominational and philosophical spheres; and Impartiality which demands action without favor or prejudice towards or against anyone.

In June, the International Council of Nurses, the oldest professional women's organization in the world, held a Congress in Rome at which nurses of 57 countries sought to improve professional standards and services in their own and other countries. The Congress concluded with this inspiring watchword from the President:

> May we grow in faith, in works, in understanding, that we may achieve wisdom, so necessary to us as professional women and citizens.

In October, the International Red Cross Conference was convened in New Delhi. This conference is the chief deliberative body of Red Cross, composed of representatives from the League, the International Committee, National Societies and all Governments signatory to one or more of the Geneva Conventions. These conferences, therefore, are of a quasi-diplomatic character and over the years have been the motive force in initiating and codifying international humanitarian law.

Flags of 83 nations fluttered in the breeze outside the Conference Hall in New Delhi to welcome the delegates. As one Indian newspaper phrased it:

> It was the biggest international assembly in India, not only because 83 nations were participating, but because more of the world's peoples were represented at this conference than in any other international organization.

The Red Cross today embraces more of mankind than any other organization, including the United Nations and its member agencies. In a very true sense it is the voice of humanity.

The theme of the Conference was "Human Rights." It could just as well have been characterized by the word

"Humanity," as it was occupied throughout by the fight against suffering and death; the demand that man shall be treated humanely under all circumstances. In common with nursing, humanity is the fundamental basis of Red Cross, indicating at the same time its ideal, the reason for its existence and its objectives. Nevertheless, as Dr. Pictet points out:

> Red Cross cannot be expected to carry out all and every task that is considered to be of a charitable or humanitarian nature. It must, on the contrary, restrict its activities to specific duties for which it is better equipped than other organizations. Only thus can it guard against the danger of dispersing its efforts so widely that it will be incapable of discharging the duties for which it is primarily responsible, and then only if supported by those who adhere to a common purpose in which you, as nurses, play no small part.

Throughout the conference many important resolutions of a humanitarian nature were submitted to the Plenary Sessions of the conference for approval. Of particular significance to the nursing profession was a long resolution of the Medico-Social Commission on the subject of nursing which stressed the need for "detailed instruction on the rights and obligations of nursing personnel who, in time of conflict, enjoy the protection of the Red Cross emblem, as provided for in the Geneva Conventions."

It has always been a matter of deep concern to the International Committee that the lives of many nurses on active service have been lost because they were not themselves aware of their rights and privileges as protected personnel under the Geneva Conventions. The International Committee feels it is not when a country is at war that this instruction should be given; it should be integrated into the peacetime curriculum of nurses.

In a democratic country such as Canada it is not possible, or even desirable, for either the government or the National Society to attempt to force such instruction on the nursing profession. Your association, however, might well consider taking the leadership in the dissemination of knowledge of the Geneva Conventions among your own members. A little pamphlet on the Conventions, issued by the International Committee entitled "Brief Summary for Members of the Armed Forces and the General Public" can be purchased for approximately one Swiss franc. To complement the "Summary" is an excellent memorandum of a few pages entitled "Some Advice to Nurses and Other Members of the Medical Services of the Armed Forces," prepared by Mlle. Lucie Odier, a member of the International Committee and herself a nurse.

Unlike so many international treaties, discraded as "scraps of paper," the greatest code of International Humanitarian Law — The Geneva Conventions — has been respected and observed by some 63 nations over the past century, many of them frequently at total war. Inspired and formulated by the Red Cross which, through International Red Cross Conferences, has given leadership to governments in the revision and extension of these humanitarian treaties, the Geneva Conventions have resulted in the proper care and treatment of battle casualties, friend and foe alike, and the protection, indeed the survival, of millions of prisoners of war.

It was fitting, therefore, that attention should be given to a set of "Draft Rules for the Limitation of the Dangers Incurred by the Civilian Population in Time of War" and submitted to the governments of the world, through the intermediary of the International Committee. A second resolution called on all nations to renounce war, intensify their efforts to bring about general disarmament and adopt measures which could effectively protect humanity from the terrible consequences of the use of incendiary, chemical, bacteriological, radioactive and other such weapons.

A further resolution sponsored by the Canadian Red Cross Society and, after initial differences of opinion, finally adopted by the conference without a single dissenting vote from participating governments or national societies, dealt with reunion of families dispersed as the result of war, internal conflicts and other events beyond the control of persons involved. This grievous problem of missing, displaced and uprooted men, women and children is not confined to any country or

to any continent, but is a human tragedy of world-wide scope. The Canadian resolution was impartial, non-political in character, designed to meet the needs of all peoples within our humanitarian traditions and framework and is of particular interest and significance to New Canadians on whose behalf we have been intervening to effect reunion in Canada of their next of kin, now resident in certain eastern European and Asiatic countries. We have had a considerable measure of success through the intermediary of Red Cross societies of the countries concerned, but with this resolution we now have new hope and encouragement. This is a task which requires patience, tact and perseverance, but above all mutual understanding and respect between us and men and women of many lands, creeds and political ideologies.

Our Fundamental Principles, according to Dr. Pictet, number only seven. The objectives of the Canadian Nurses' Association are even more modestly stated, numbering as they do only four. I am sure, however, that your accomplishments in the brief half-century of your existence would not have been possible were it not that behind and beneath your stated objects are others identical with the Fundamental Red Cross Principles. I have been able to do no more than briefly outline the Principles, which are permanent, unchanging and universal, as long as strife, fear, suspicion, hunger, suffering and pestilence stalk the world. If you and we had only one principle, it would be humanity, which is our primary and essential vocation, the preservation of the dignity and welfare of men, women and children of all countries, of all philosophies of life.

Next year, you, as nurses, will share in the celebration of the birth of the Red Cross, because in your own profession you are dedicated to upholding the Principles of Humanity, Neutrality and Impartiality. They have outlived Henri Dunant by many years and will outlive all of us who are serving them today. We shall have fulfilled our purpose if we pass on to another generation this, our common heritage, with Principles untarnished.

In the Good Old Days

(*The Canadian Nurse* — OCTOBER, 1918)

I often think that in our Schools of Nursing we have been living in the past. I believe we did, more than many, look back on precedents. We either live in the past or we are working hard to maintain the present current situation, but I am sure we have not looked far enough into the future . . . It is a very good thing for us to have to waken to the fact that if our schools are to render the service they ought to render, we must look into the future.

* * *

Canada has a great industrial future but you cannot have a great industrial future without a healthy people. Inevitably nurses must have a big share, a large and important and deep-seated share, in the maintenance of the health of the people, wherever they are. Nothing is more certain than that.

* * *

Scarlet fever, diphtheria and measles cost the people of Chicago about $7,562,422 for the year 1916. Much, if not all of it, might have been prevented. It can confidently be asserted that this tremendous bill was due largely to carelessness and indifference.

* * *

The *Journal* of the American Medical Association called attention to recent literature on the subject of preoperative purgation. It had been stated by one researcher that after vigorous catharsis the isolated musculature of the bowel is no longer as responsive to stimulus as it is normally and is more easily fatigued. What is to be gained by the evacuation? Sterilization of the intestine is impossible. Purgation leads to loss of water and intestinal secretion, both very valuable. A simple enema before the operation is all that is necessary.

* * *

The firemen of Montreal knitted, from January 1st to August 1st, 3000 articles for the sailors. In one month they sent 400 pairs of socks, 275 sweaters and 100 scarfs. One energetic fire-fighter knits a sweater a day, and few women can equal his workmanship.

The World at your Finger-Tips

HELEN G. MCARTHUR, M.A.

OVER A YEAR AGO, in Rome, the president of the International Council of Nurses, the oldest international professional organization in the world, sent delegates from 57 countries back to their individual nations with these words —

> May we grow in faith, in work, in understanding, that we may achieve wisdom, so necessary to us as professional women and citizens.

Then she gave the ICN the watchword *Wisdom* for the next four years. Some 225 Canadian nurses sat in that gathering and with deep emotion, felt the mighty impact that nursing makes on the international scene. Well aware of an uneasy universe, filled with fear of war, continued and mounting political tensions, these nurses of the world through their common bonds of purpose and preparation, based solely on their concern for human need, create a stabilizing influence that is a ray of hope for the future of mankind.

It seems quite possible to me that every one of the thousands of nurses at that congress said to herself, "The world is at my fingertips. It is true — just look around me." Nurses of Japan sat next to those from Liberia; the president of the Irish Nurses' organization introduced the new member from Ethiopia; Turkey chatted with France; Norway greeted Brazil; Great Britain watched with pride the representatives of the new nation Ghana; the United States of America greeted a neighbor from Trinidad; Iceland congratulated Yugoslavia; Canada renewed old friendships from Korea. Thus it went down the long list of nurses encompassing the globe. Everywhere was re-echoed the words of Mrs. Dolly, the president from Trinidad.

> The International Council of Nurses has, for over fifty years, stretched hands of friendship around the world, and we know, in spite of a series of human conflicts, has been able to maintain and to strengthen those bonds of affection.

Wisdom — hands — fingertips! What significance have these words for you, the student nurses of Canada? Are you saying to yourselves, "How soon is all this for me?" How soon are the fingertips ready to grasp desired opportunities and use them wisely?

How fortunate you are to have had the opportunity to see and hear outstanding nurses who are making a very real contribution to nursing, and through nursing, to the peace and well-being of the world. Each one in her own way has given you a clue to your own future and illustrated how you may take advantage of the opportunities that are available to you as future Canadian nurses. I am quite certain each one would say, "I would be nothing without the knowledge that the nurses of my country support me in my work by setting examples of good nursing." Before being accepted away from home the individual nurse must first have demonstrated the best in nursing in her own setting. Before she can carry on, there must be reserves of nursing leadership upon which she can call, either for nurses to serve in other lands or as examples to illustrate what can and should be accomplished.

Nurses such as these are the *fingertips* that reach and touch the far corners of the world. But they are helpless unless the *hand* behind them is strong and skillful. You are an important part of the hand of nursing that raises these people to the top of nursing leadership. You are the future of nursing. The assurance of your continued enthusiasm, creativeness, courage, understanding and sincerity makes it possible for them to carry on in the face of many difficulties.

Nor is the hand enough. Is not the watchword Wisdom? No matter how skillful the hand, if it is not directed and motivated wisely, the skill may not be accepted. The hand may be pushed away by those it seeks to help. Per-

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Miss McArthur, well known as the Director of Nursing Services for the National Red Cross Society, gave this address at the luncheon for the student nurses attending the CNA Convention.

haps it may even destroy when it tries to assist. This thought reminds me of the story of the kindly elephant. One day as she ambled through the forest, the mother elephant brushed a robin's nest from a tree and, stumbling, stepped on the mother robin and killed her. The elephant was devastated. She felt she must do something to help this tragic situation. On the ground was the nest with the three small eggs nearly ready to hatch. "I will make up for my destructive error," said the elephant. "I will give up what I intended to do and give my time to hatching these eggs." She knew what was needed and so she settled herself down on the nest of eggs! ! !

During the Hungarian Revolution a second-year student nurse eagerly offered her services to go overseas and serve the suffering refugees massed in unprepared and overcrowded centres in Austria. In all sincerity she was ready to put off for a time the completion of her education and her own plans to go to university, in order to assist those less fortunate than herself. And what did I say to her? First, I said thank you for the heart that motivated her to help others, the unselfishness that made her willing to sublimate her own plans to the needs of others. Then I added, "But experience has taught me that it is wisdom to make haste slowly." I spent several pages of a letter explaining what I meant by this very conservative statement. I expect she said, on first thought, "There it is again — that's what the *old* ones always say! There is no time to go slowly when the world is in a great upheaval."

I wouldn't be a bit surprised at her reaction. I too had just such a thought in 1939. I was going off to Columbia University to study on a Rockefeller Fellowship. I had left my nursing post in the far north, a qualified nurse with some five years' experience. I was quite secure in the knowledge that I was a fairly good nurse or I would not have been given an opportunity to get further preparation in teaching and supervision.

I was busily packing my trunk with the radio playing on September 1, 1939. "Poland invaded" came the flash. With shocked minds we listened until September 3rd. Great Britain and France declared war. Canada followed. I remember quite clearly thinking, "Well, Helen, that's that." I packed myself on to the train and reported for duty at headquarters, quite ready to do whatever would be expected of me. And how was I received? With a surprised look my chief said "What are you doing here? I thought you were on the way to University." But things had changed! The world was at war! I could nurse under most circumstances!

The kindly face looked at my youth and said, "Do you not believe the world will still be here next year? Do you not see that you may be needed even more *then*, especially if you are better prepared to take leadership? Leaders are always in short supply. It is wisdom to make haste slowly. To make the contribution we need from you, *get ready, step by step.*"

So, I went back to school while others went off to settle the world. I remember feeling that I would miss the opportunity to see the world. But my seniors knew I was not ready to do the things that would later be open to me and would eventually take me to Europe, to South America and to Asia. I had to have *wisdom* to guide the hand before my fingertips were ready to serve the world.

Was it the university degree I obtained that opened the way, you may ask? It helped! Wise teachers in universities give their students sound principles on which to base their thoughts and actions but this alone was not enough. Every nurse needs experience to translate principles into action. Experience to be sound and of value to others, needs to be taken step by step. The first test is more comfortable if taken in familiar surroundings where you know and understand, where you are known and understood.

Later comes a new testing ground, perhaps in a rural situation where no supervisor is readily available day and night; where there is no interne; where the doctor often has so many demands on him that you may have to think and act for him; where there is little or no complicated equipment — perhaps no plumbing or electric lights. There you learn that good nursing does not depend on the things around you, but on *you* and your ability to

nurse people under any circumstance.

In time you will find that you want a few more skills and a lot more knowledge. When you have selected your particular future, whether it be psychiatry, pediatrics, obstetrics or the operating room; whether you choose teaching, administration or public health from the endless opportunities open to you, you will want to go back to studying. Nurses with leadership qualities and broad preparation are needed at every turn. You will know when you need further tools to take up the job before you. Then you will find Canadian universities ready and waiting to meet your need.

If you are one of the fortunate Canadians who comes from a home that gives you more than one language you will be doubly blessed. In Korea I would have been twice blessed if I had spoken French fluently and thrice blessed with German. While your minds are young and resilient grasp every opportunity to speak another language, any other language, so that you may warm the heart of someone in another land some day, or find yourself better fitted to understand the problems of those who come to our shores to seek a new life from many parts of the world.

However, even here experience pays dividends. Having failed to acquire facility in other languages, at least my years of trying to communicate in English in a form readily understood by the beginner in the language, gave me my most recent compliment. A doctor recently visited Canada from the Polish Red Cross. His only English prior to coming to this country was learned from records on a Linguaphone. After a most satisfying discussion between us through carefully selected words on both our parts, he bowed low and said, "It has been a great pleasure to speak with you. It was most easy. You speak just like a gramophone."

Of course, while you are developing the art of nursing you will take part in your professional organization. You will join in the companionship and constructive work of your alumnae association. Offer your enthusiasm to the registered nurses' association of your province and gradually learn what nurses can accomplish when they work and plan together. You will read of other lands; meet and talk with as many people with varying cultural backgrounds as possible, and so increase your understanding and add to your wisdom. You will ponder with concern the thought that three out of five people in the world are hungry. You will try to comprehend the lessons of hunger. The Koreans used to tell me that it is easier to travel the long hard road of hunger if you practice this philosophy:

> If you must choose between one meal a day and music and laughter or two meals a day and no music and laughter, there is no choice. You can survive hardship much better on a full mind and an empty stomach than on a full stomach and an empty mind.

Does this have meaning for you? The hungry people of the world say it is not so difficult to go hungry if one knows that those who eat well at least care about those who do not.

Can you imagine yourself working in a situation, such as Korea, where there is one nurse to three doctors and scarcely one nurse for 10,000 people? There are countries in which this figure climbs to 100,000 people. How can you prepare yourself to work in a situation like that, having learned your lessons in a country that has approximately one nurse to 300 people? Do you see why I suggest rural experience as a small eye-opener? How quickly nurses who must face such difficulties will respond to you, if you can demonstrate that you, who have had the advantages of modern equipment, scientific knowledge and the help of many hands, can adapt your art to reality; recognize that success is a progressive attainment and that the greatest success is doing the best you can with what you have and know, wherever you are.

Again I say, it is wisdom to make haste slowly. Some of you may follow in the footsteps of our present nursing leaders in the world. There are opportunities in the Colombo Plan, the World Health Organization, the Red Cross, the missionary field, the International Council of Nurses. But, you say, there are thousands of us and in comparison, so few international positions. Are the rest of us to be denied the right to have the world at our

fingertips too? Of course not, or I would never have chosen to speak on this particular topic. My interest is in *all* nurses not just the chosen few. It is my belief that the greatest contribution you can make to internationaal nursing is by being a good Canadian nurse in your own setting. To make this contribution you must be so good that the story of your work will resound about the world. Then, through your example, nurses all over the world will feel your leadership; will take heart to try again against great odds; will take pride in association with you as members of the International Council of Nurses; will say of your time, has stretched hands of friendship around the world and we know, in spite of a series of human conflicts, has been able to maintain and strengthen those bonds of affection.

The International Council of Nurses

This week we celebrated the passing of fifty years since the founding of the Canadian Nurses' Association. We are proud of what has been accomplished. The next fifty years are in your hands. The world is at your fingertips. Make Canadian nursing a full strong light that will reach to the far corners of the globe to banish hunger, illness, suffering, ignorance, fear and hatred and so, with wisdom, seek for all peoples a life of health, happiness and peace.

The Retirement Plan

WILLIAM F. CASSELL

FOLLOWING ENTHUSIASTIC endorsation by the delegates at its 50th anniversary meeting held recently in Ottawa, the Canadian Nurses' Association announced the commencement of a retirement plan for its members. The plan is similar to that adopted by the Canadian Medical Association last year with an additional provision permitting employer participation.

The plan combines the safety of an Insured Annuity plan through the facilities of the National Life Assurance Company of Canada and a hedge against further inflation through a Common Stock pool managed by the Royal Trust Company. Arrangements have been made whereby the Bank of Montreal will accept regular contributions and transfer these funds to the plan.

All members of the CNA who have not attained age 70 may join the registered savings plan. Normally, members who join this portion of the over-all plan will be in one of the following groups:

(a) Self-employed.

(b) Employed in an organization which does not have a registered employer/employee pension plan.

(c) Employed in an organization and a member of its pension plan, where such plan does permit additional optional employee contributions of sufficient magnitude.

Members may contribute any amount up to 10 per cent of earned income with a minimum requirement of $100 annual contribution. Contributions can fluctuate year by year within these limits.

In each contract year the first $100 of the members' contribution to the savings plan will be directed to the insured annuity fund. As soon as $100 has been contributed the remainder of the members' annual contribution will be allocated between the insured annuity fund and the common stock fund at the direction of the member. The percentage allocation may be changed once a year.

Contributions within the limits stated above are fully deductible for income tax purposes. Benefits arising on the death of a member are taxable at a flat rate of 15 per cent. Annuity benefits received are fully taxable as income to the recipient. The funds,

Mr. Cassell is group sales secretary with the National Life Assurance Company of Canada.

when so deposited, are locked in and can only be withdrawn in the form of death or annuity benefits.

Retirement is permitted at any time prior to age 71 on a quarterly valuation date, (March 1st, June 1st, September 1st or December 1st).

Of particular interest to hospitals and to others employing members of the CNA is the feature whereby they can establish registered pension plans covering their nurses. One year of continuous service with the employer is required for participation in the plan except that employees who are members of a registered employer/employee pension plan incorporated in this arrangement will be eligible to join the plan immediately on joining the service of a new employer participating in the plan.

Employee basic contributions will amount to 5 per cent of earnings but additional optional contributions are permissible. The employee may allocate her basic and optional contributions between the insured annuity fund and the common stock fund in any proportion desired. This allocation factor can be changed once a year.

Employers who institute the plan will contribute 5 per cent of the employees' earnings each year subject to a maximum contribution of $1,500 per year on behalf of each employee. Employer contributions will be directed automatically to the insured annuity fund.

Employee contributions are fully deductible in computing the employee's income tax. Employer contributions are considered as deductible expense for taxation purposes and are not added to the employee's income.

At retirement, normally age 65, the individual will receive a guaranteed or fixed number of dollars of monthly retirement income related directly to the amount of the contributions made on her behalf to the National Life Assurance Company. In addition, the value of the members' common stock account will be transferred to the insured annuity fund over a 5-year period prior to retirement and will be applied to purchase annuities. The combined retirement thus purchased is guaranteed for 10 years and for lifetime thereafter.

The Canadian Nurses' Association over-all plan became effective on the 1st of September, 1958, and all members of the Association have been sent a booklet fully outlining the entire plan. Hospitals and other employers of nurses will receive the booklet also.

The plan will be administered by the Canadian Nurses' Association National Headquarters in Ottawa and nurses or their employers wishing to participate in the plan should direct their inquiries to:

Miss Pearl Stiver, General Secretary,
Canadian Nurses' Association,
270 Laurier Ave., W.,
Ottawa, Ontario.

La Croix-Rouge de Thaïlande ayant fait appel à la Ligue des Sociétés de la Croix-Rouge, la Société canadienne de la Croix-Rouge, leur a fait parvenir pour plus de $4,000 de vaccin contre la choléra afin de combattre l'épidémie qui sévit à Bangkok. Le vaccin a été expédié à la Thaïlande de la base d'aviation McGuire, à Trenton, N.J., à bord d'un appareil de l'aviation américaine qui transportait en même temps un équipement gratuit offert par la Croix-Rouge américaine ainsi qu'une provision de vaccin fourni par le gouvernement américain. Le Dr W. S. Stanbury, commissaire national de la Croix-Rouge canadienne, a déclaré que tout l'approvisionnement canadien de vaccin contre le choléra, y compris celui des dépôts de la Défense nationale, était compris dans cet envoi. Le gouvernement de le Thaïlande a annoncé que l'épidémie se propageait rapidement et a lancé un appel dans le monde entier pour obtenir 4,000,000 doses de vaccin contre le choléra afin d'inoculer toute la population. Le choléra est une maladie inconnue sur le continent nord-américain. C'est une affection aiguë caractérisée par le vomissement et la diarrhée. Le vaccin n'étant pas utilisé au pays, il n'est entreposé qu'en quantités restreintes par des compagnies pharmaceutiques.

* * *

When the delegates to the American Conference on Rheumatic Diseases met in New York 15 years ago, all they talked about was pulling teeth and removing tonsils. Last year when they met they talked about hormones and emotions. Probably about a third of the victims of sore joints have trouble which is essentially psychogenic, originating in the mind. Often the real trouble is not a focal infection but a focal conflict.

—*Canadian Hospital*

Sociogramatic Study of Spontaneous Patient Groupings

B. Harvey *and* R. Monk

Here will be presented some of the results found from a survey of Natural Groupings in a hospital unit. This survey was made in the Day Hospital of the Allan Memorial Institute of Psychiatry, Montreal.

Before presenting these, the Day Hospital should be briefly discussed. Three main purposes of this department are:

1. The treatment of a psychiatric patient in hospital while remaining in direct contact with his family group.
2. The psychological weaning of the patient from the support of the day and night hospital, to society.
3. Lower hospitalization costs for the patients.

The maximum capacity is 40 patients, the average length of stay is 31 days. Both sexes, preferably over the age of 18 years, are admitted. All types of patients are admitted, with the exception of those whose behavior is too disturbed, suicidal patients, and those who live more than one hour's travelling time away from the hospital.

Also admitted are patients transferred from the day and night section who no longer require constant support.

Patients come in six days a week, 8:30 a.m. to 5:00 p.m. Physical treatments are given in the morning and day medications are given three times daily with necessary night sedation taken home each evening. During the day, patients participate in occupational therapy, ground and group activities with the rest of the hospital.

The authors were postgraduate students at the Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, in May, 1958.

The assistance of: D. E. Cameron, M.D., F.R.C.P. (C); A. Richman, M.D.; G. Taylor, M. Sc., M.D. C.M.; R. L. Hutson, M.A.; P. C. Pike, R.N. with various aspects of this study is gratefully acknowledged.

Methodology

The information here presented has been collected over a period of one month. Two sociograms were drawn each day, at different times, to indicate what the patients were doing. This survey was done merely to show the natural groupings as they existed and we were mainly concerned with "how do patients group together?" rather than "why."

The following sociogram shows the type that was drawn and the other examples shown are excerpts used to demonstrate our points. Patients are shown diagrammatically by the small lettered circles. Larger circles are used to define group formation, and arrows the interaction between members. Popular group members or leaders are indicated by a star, and broken circles indicate groupings of mere physical proximity. (See figure 1)

A mutual interest in occupational therapy appeared to stimulate group formation. Often one patient would influence another to go to this department with the group, sometimes more effectively than attempts made by the staff. Possibly the fact that occupational therapy brings the patient into a group may provide the greater part of motivation in some cases.

One patient, A, noted as the star of this group, felt very keenly that this was a substitute home. Patients did their laundry and some cooking here, as well as the regular crafts, and to A it was an important part of the day when she could make morning and afternoon tea which she served to staff and patients. Here they stopped their work for short discussions or joking on varied subjects. We felt that she, as hostess, played an important part

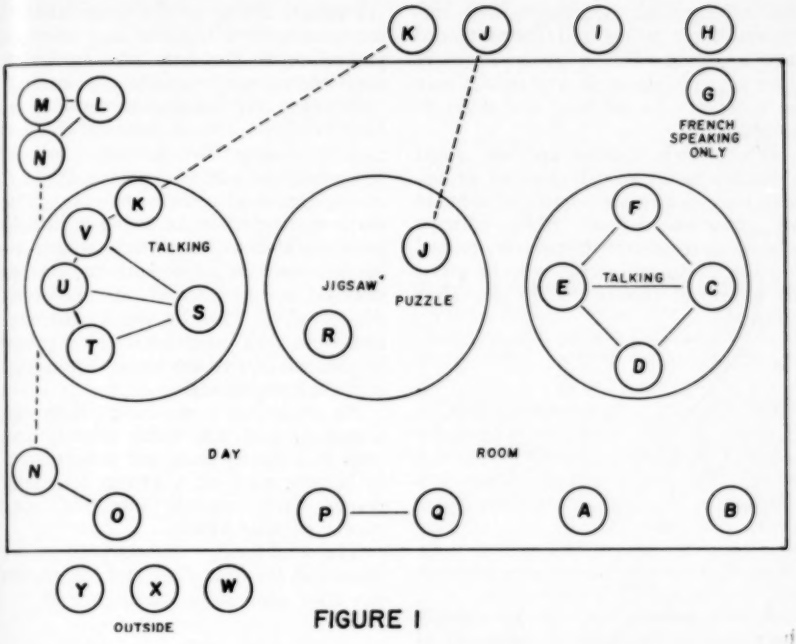


FIGURE I

in the formation of this group in a setting which was conducive to this.

The basic structure of this group could still be seen when they were in the Day Hospital, but they were less consistently together and mixed with others as well.

We noted at least two patients, B and C, in this group who had tended to be quiet and isolated on the ward but became well integrated into the occupational therapy group.

Patients from other wards joined this group, but not so closely as those from the Day Hospital (A to M). (See figure 2)

Patients frequently formed groups according to sexes, although the boundaries of these were by no means inflexible.

Group A, shown below, is made up of women, all in a grouping. These groupings were seen for men in games such as volley ball or for outdoor activities in pleasant weather. They were seen for women during "confidential chats" or discussions of household topics. These groups seemed fairly easily entered by one of the opposite sex, whereupon the topic usually turned to one of more general interest. (See figure 3)

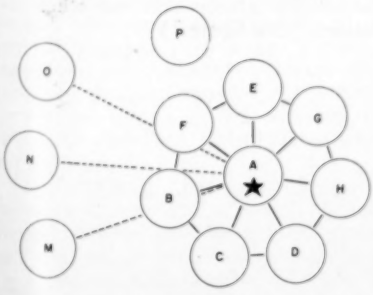


FIGURE 2

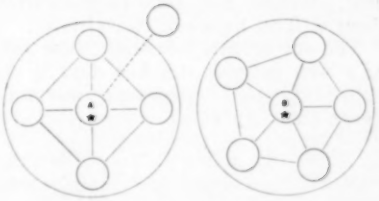


FIGURE 3

It was felt that the furniture arrangement and spaciousness of the day room could be a help or hindrance in group formation. Chairs may be placed too far apart to permit easy conversa-

tion among their occupants, with numerous little tables and lamps placed between them. For a group of more than four people to sit and talk it may be necessary for at least one chair to be moved.

While such factors are not great obstacles to an already formed group, they may not foster communication to an optimum degree. Also, patients who wish to isolate themselves, or feel too shy to do otherwise, may be given an excellent chance to do so. (See figure 4)

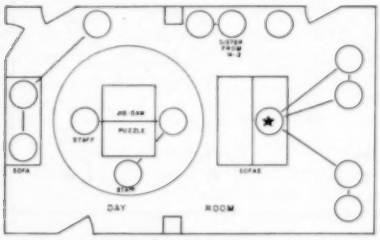


FIGURE 4

A new patient may be drawn into the group on the basis of similarity of interests or background, either with the group or one established member. Such similarities seemed to break the ice at the first meeting and were strong facilitators during the period of integration.

In the sociograms, A was the new patient and B the star of the group. They quickly discovered that they came from the same district, frequented the same places of entertainment, and had a few mutual friends. One other member was also from the same district. The other members soon followed the example of their star and became friendly with this girl who was neat, pleasant, and could keep up with them well on topics of conversation.

The sociograms following show her as a new patient, and five days later, apparently well integrated into this group (See figure 5)

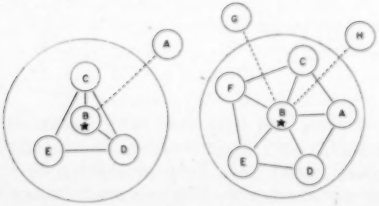


FIGURE 5

Patients living in the same district often commuted together but this appeared to be the only way in which they related much outside the hospital.

Patients on admission tended, at least briefly, to isolate themselves. This usually disappeared as they became more familiar with the routine, the surroundings, and other patients. The majority made friends, either with help from the staff or interested patients, or by their own initiative with one or two persons by the second day, enlarged this to about four by the fourth day, and were well integrated into a group by the end of two weeks, with the help of these first friends.

As an example we have shown A, a teenage girl who made friends first with B, a young man, and progressively became part of a group of young people with mutual interests, e.g., sports, popular music.

The following sociograms were drawn on the first, fifth, and fourteenth day after admission. (See figure 6)

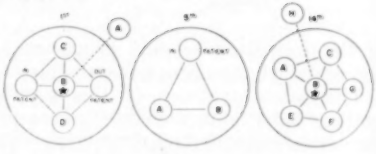


FIGURE 6

At 2:00 p.m., when tea is served, there tended to be more definite groupings, purely for discussion, rather than for activity. The conversation consisted of varied topics and good-nature joking, as might occur anywhere where people gather for brief refreshments.

Shown in the following sociogram, they formed fairly large groups, while still retaining the basic structure of the smaller groups seen on other occasions. (See figure 7)

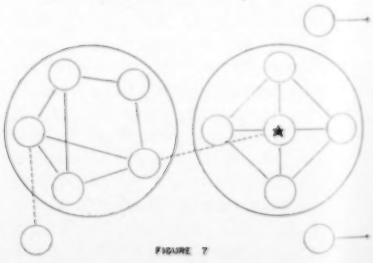


FIGURE 7

The time of day seemed to play an important part in the grouping of patients. When patients were having physical treatment or were in occupational therapy there were, naturally, fewer ward groups and these subject to interruptions for therapy.

In the first sociogram, following, it can be seen that only one group of any size was formed and that many persons were otherwise occupied. This contrasts to the second which was taken after dinner and before afternoon activities had started. Here, while there were still some isolates, there was much more tendency for the patients to get together in groups. (See figures 8 & 9)

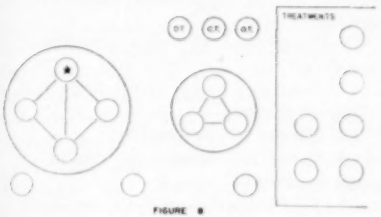


FIGURE 8

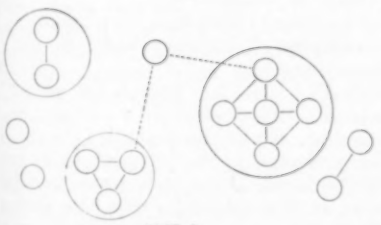


FIGURE 9

We noticed two types of patients, equally popular with the others, both being associated with about the same number of people. One appeared to be a "rotator," while the other appeared to be a group organizer and leader.

As seen in the left sociogram, A mixed well with many people, in or out of groups. They were of varied ages and both sexes. Although this was so, these people did not become integrated into a group, nor was he himself assimilated into an already formed one.

Patient B, in the right sociogram, shows a contrast to this in that she had nearly always an integrated group around her, of which she was the star or leader. (See figure 10)

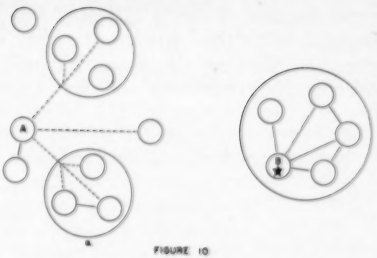


FIGURE 10

An obstacle which prevented many people from becoming part of already formed groups was their language. This, on the other hand, tended to bring them together into groups of their own.

During the study, patients were observed who spoke English, French, Rumanian, Yugoslavian, and Yiddish, with many being bilingual. This led to the formation of groups where the members could express themselves most easily. Particularly strong were groupings in which one person spoke in his native tongue and another spoke English as well. A dependence arose on the one who could interpret to the staff and explain things to them.

Elderly ladies tended to be dependent on each other for company, particularly in twos. For example, two ladies who were about 70, both shunned physical activity and impersonal topics, and both spoke English and Yiddish. There appeared to be little common bond between them and other groups.

Also, some young people of opposite sexes found it desirable to form these groups of two. They had many similar interests such as volley ball, rock and roll music. The boundaries of these groups seemed less inflexible than those of the older age group, and they mixed into larger groups when they so wished.

Some patients, because of the nature of their illness, of which seclusiveness was a factor, made no close contacts on admission or later. Attempts of other patients to make friends were met with politeness, but brief answers, until most of them seemed discouraged.

Here we have shown Miss A, a long term schizophrenic with whom doctors had difficulty in establishing a relationship and whose limited knowledge of any language but Rumanian also made

communication difficult. The following sociograms were drawn at weekly intervals, showing almost no change in interpersonal relationships. (See figure 11)

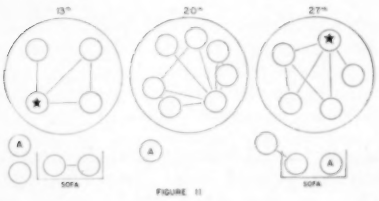


FIGURE 11

The next sociogram shows the influence of the nurse in a group discussion. This took place, unscheduled, at tea time when a few were discussing a routine social activity. The nurse was brought into the discussion and as questions were asked, opinions exchanged, more patients began participating.

It is perhaps important to note a subject of interest to all, and the ability of the nurse to act as coordinator. (See figure 12)

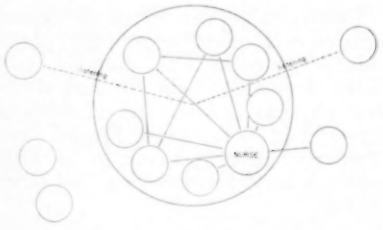


FIGURE 12

Discussion

Because sociograms were taken at different times during the day, it could be seen over a period of days how any particular patient spent his time, what treatment he received, and what activities he participated in. From the ones presented here we can see that there are many factors which draw people naturally together, such as age, sex, language, activity, treatments and common interests.

Implications of Study

After they were completed, the sociograms were reviewed and the information we could draw from them was remarkable to us. We realized the value they could be to a ward as a means of relating a patient's behavior.

Some possibilities for future use that we would like to mention concerning the patient are:

1. How he fits into the ward setting
2. How he participates in a group
3. Whom he associates with
4. How he spends his time and what activities he prefers.

On the hospital team the nurses, doctors, psychologists and social workers are interested in the patient. The nurse spends the most time with the patient and describes his behavior to the team as she sees him. The sociogram may be a method of communicating to each the information with which he is specifically concerned, such as:

1. Progress of the patient since admission
2. Nature of group participation (active or passive)
3. Manner of spending time
4. Patient's response to medication and treatment
5. Visual description of the patient in the ward structure
6. Patient's preference in activities and associates, (particularly useful to the new nurse).

Sociograms are "proof on paper" which is often better than verbal communication, and can point out the need for a change in the physical structure of the ward. These sociograms can be done in five minutes a day. We found that they certainly increased our powers of observation and made us more aware of the process and nature of social groupings.

Conclusion

The drawing of sociograms was found to be a useful method to indicate the natural group formations in the Day Hospital, along with the various factors that influence them.

* * *

To smash the simple atom
All mankind was intent.
Now any day
The atom may
Return the compliment.

—*The Weather Vane*

The Inspection of Ward Drug Cabinets

BENJAMIN TEPLITSKY

EVERY WARD DRUG STATION may almost be considered a "miniature pharmacy" with a nurse in charge. The size of the hospital will determine the number of such drug stations. It therefore behooves the chief pharmacist to establish a policy* of inspecting these "miniature pharmacies" and seeing that personnel comply with hospital regulations in regard to their proper operation as well as their maintenance.

The proper care of such drugs directly reflects the supervision by the chief pharmacist. A clean and orderly drug cabinet indicates good drug habits originating at the pharmacy and encompassing the nursing unit.

In making these inspections the pharmacist should always be accompanied by a nurse supervisor. He is then able to point out irregularities of drug maintenance and at the same time have something pleasant to say to the supervisor when the drug cabinets are in proper order. The information received by the supervisor is relayed to the nurse in charge of the ward being inspected.

A good check list to be used by an inspecting pharmacist may resemble the following with modifications to suit the needs of the particular hospital:

1. *Drug cabinets:*

a. Are sample drugs permitted in the drug cabinets? If not, the nurse should be requested to remove any found there and return them to the owner. The policy regarding drug samples should be set by the Hospital Drug Committee.

b. Are any non-approved drugs in the cabinets? If so, remove them with proper instructions to the nurse. Again, the policy of the Hospital Drug Committee will determine the proper disposition of such drugs.

c. Are certain drugs in excess of the needs of the ward? All such excess drugs should be removed from ward drug cabinets and returned to the pharmacy for reissue where practical.

d. Are any labels soiled, mutilated, or illegible? If so, request the nurse to return such containers to the pharmacy for relabelling.

e. Are there any drugs that have been discontinued because the patient has been discharged, has expired, or medication has been discontinued, or any drugs that have been recalled by the pharmacy? If so, have them returned to the pharmacy for proper disposition.

f. Are investigational drugs separated from regular drugs? If not, request that the nurse keep such drugs apart from routine drugs. Also check all the precautionary labels such as "Not for general use," name of investigational drug, with strength, name of patient who will use such drug, and other pertinent information regarding it.

g. Are there non-drug items in the cabinets? If there are such items as patients' wallets, jewelry, or other personal belongings, inform the nurse that such items should be sent to a place of safekeeping in accordance with hospital regulations.

h. Does the nurse maintain proper security over drugs stocked in ward drug cabinets? Is the drug cabinet locked when all nurses on the ward are busy attending patients?

i. Do you find the drug cabinets clean and dust-free?

j. Are the internal preparations separated from the external ones?

k. Are the drug containers in the drug cabinets uniform? Weed out any off-size drug containers that are found.

l. Are any drugs in containers other than those issued by the pharmacy? If so, instruct the nurses that only pharmacy personnel are authorized to label drug containers.

m. Are ophthalmic solutions in colored bottles in quantities not exceeding 15 cc.? Are all eye solutions dated as to time of preparation? Remove any eye solutions that appear to be deteriorated

Mr. Teplitsky is Chief, Pharmacy Service, Veterans Administration Hospital, Albany, New York.

* At V.A. Hospitals and Clinics in the United States such policy is established by regulation and is mandatory.

regardless of date of preparation.

n. Are there biologicals that should be refrigerated?

o. Are there out-dated drug items? Pay special attention to non-refrigerated antibiotics and ophthalmic preparations. Check the dates when certain solutions were prepared so that after the specified period of time, these solutions may be discarded.

2. *Biological refrigerator:*

a. Is the refrigerator in proper working order?

b. Are there any out-dated products?

c. Is care taken that only drugs requiring refrigeration are in the refrigerator?

d. Do you find any food items that do not belong in the refrigerator? Are fruit juices and other food items that are taken in conjunction with medication identified by a notation, "For use with medication."

3. *Narcotics and habit-forming drugs:*

a. Do current ward records on narcotics and habit-forming drugs agree with records maintained by the pharmacy?

b. Are special security measures maintained for narcotics and habit-forming drugs?

c. Do some narcotics indicate no usage over a long period of time? If so, request that they be returned to pharmacy in accordance with hospital regulations.

4. *Ampoule section:*

a. Do you find any ampoules in excessive quantity? If so, request that the extras be returned to pharmacy.

b. Are any ampoules deteriorated? If so, remove them from the ampoule section and see that a replacement is made.

c. Do you find any out-dated ampoules? If so, remove them and make a replacement.

d. If any vials of powder are reconstituted, do you find dates of such reconstitution on the vial? If not, and the nurse cannot remember the date, discard such vial if the potency is dependent upon the time of reconstitution.

e. Do any of the reconstituted vials require refrigeration? If so, instruct the nurse for future occasions.

5. *Bulk pharmaceutical section:*

a. Do you find excessive amounts of sterilizing solution, soap solution, deodorizing solution, alkaline mouth wash, or other preparations requisitioned from the pharmacy in bulk quantities. If there is a tendency on the part of the nurse to "hoard," inform her that requests for such items will be honored by the pharmacy at all times.

b. Are all external preparations kept apart from internal preparations?

c. Are any non-drug items in the bulk pharmaceutical sections? If so, request the nurse to remove them.

In the interest of patient safety and hospital economy, periodic inspections of drugs on wards become almost a necessity. Inspections *per se* are not enough. It is important that following such inspections deficiencies observed should be checked again to determine whether they have been corrected.

Gateways to the Mind

Experiments by Canadian doctors on the human senses will be shown on television November 2, 1958, when the Trans-Canada Telephone System's latest Science Series production, is telecast over the Canadian Broadcasting Corporation's coast-to-coast network.

The experiments, carried out by Dr. Wilder G. Penfield, O.M., C.M.G., world-renowned brain surgeon of the Montreal Neurological Institute, and by doctors at McGill University, form a part of the hour-long film sponsored by the telephone companies to help stimulate the interest of young people in scientific careers. Dr. Penfield will appear in "Gateways to the Mind" to explain some of his findings in operations on the cortex of the brain during which, by stimulating the surface of the temporal lobe with an electrode, experiences from the patient's past are relived as though they were being experienced for the first time.

An experiment proves that man cannot live without the stimulation of the human senses. Volunteers for the experiment were swathed in soft clothes and placed motionless on comfortable beds in dimly-lighted sound proof boxes. As a result of this experiment, no volunteer was able to endure the test for more than 48 hours because of the frightful hallucinations suffered.

A 16-mm. color film will be made available to schools and other interested groups following the telecast by calling the local business offices of telephone organizations throughout Canada.

Nursing Profiles

Last July, **Gladys Josephine Sharpe**, R.R.C. embarked on a new interesting assignment when she became the head of the Nursing Consulting Service of the Ontario Hospital Services Commission.

As the hospital insurance plans, sponsored jointly by the federal and provincial governments, have emerged from the long years of discussion to vigorous implementation, considerable concern has been felt by professional nursing regarding the possible effect of this development upon the education of students of nursing. How would nursing service in hospitals fare?

There is grounds for reassurance in the appointment of a nurse of such high calibre, integrity and experience to initiate the Nursing Consulting Service in Ontario. Miss Sharpe has given outstanding leadership in every avenue of nursing work she has entered. A graduate of Western Hospital in her native city, Toronto, she was early awarded the Beatty Scholarship for postgraduate study in nursing education. With her certificate in teaching from McGill School for Graduate Nurses, she returned to her Alma Mater as instructor in science for eleven years less one. Awarded the Florence Nightingale Memorial Scholarship by the Canadian Nurses' Association, Miss Sharpe took that year away from teaching to study administration in schools of nursing at Bedford College, University of London. Not long after her return to Canada she became assistant principal of the School for Nurses, T.W.H. She also holds her B.S. degree from Columbia University.

World War II intervened. In 1940, Miss Sharpe enlisted in the RCAMC and became matron of Toronto Military Hospital. She was matron of the Camp Borden Hospital when she was appointed senior matron of and liaison officer between the Canadian nurses who joined the South African Military Nursing Service and that government. Miss Sharpe received the Royal Red Cross for meritorious service at an investiture by Field Marshal Jan Smuts in Ottawa.

Returned to civilian life, Miss Sharpe became principal of the school of nursing at Toronto Western Hospital. Two years later, she was persuaded to become director of the recently organized School of Nursing Education at McMaster University, Hamilton. In 1949 she returned to the position she has recently vacated as director of nursing at Toronto Western. During the past nine years she has frequently been called upon to study the nursing service and education problems in hospitals other than her own. She was the mainspring behind the establishment of the Atkinson School of Nursing at Western.

(Ashley & Crippen - Toronto)

GLADYS J. SHARP

With all of this activity, Miss Sharpe has played a prominent and important role in professional nursing. Her period as president of the Registered Nurses' Association of Ontario was followed by a term as president of the Canadian Nurses' Association. Despite these heavy responsibilities she has always remembered the gentle courtesies of the kindly word of encouragement, the generous sharing of learning opportunities, the heart-warming welcome to nurses from near or far.

A new secretary-registrar has assumed her duties with the Association of Nurses of the Province of Quebec. **Helena Friesen Reimer**, a graduate from the Winnipeg General Hospital, with her B.N. from McGill University, her M.A. in administration in nursing education from the University of Chicago, is eminently qualified to give outstanding leadership in this busy association office. Her working knowledge of both French and German will be a tremendous asset in meeting the steady flow of nurses from other lands who arrive in Montreal.

HELENA F. REIMER

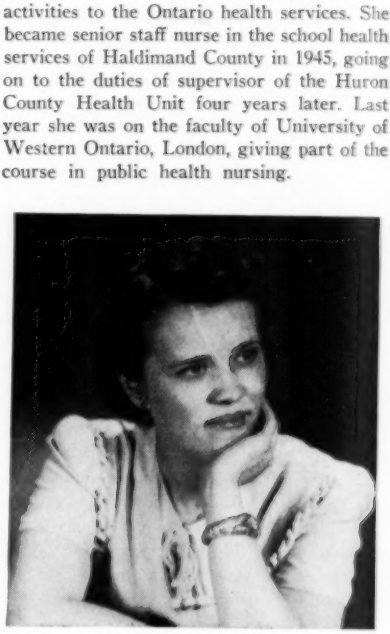
A goodly proportion of Miss Reimer's professional career has been spent in nursing service on the international level. After some years as head of the clinical teaching department at Winnipeg General she volunteered in 1944 for work with UNRRA. Her first assignment was as nursing supervisor in the Middle East refugee camps in Egypt. There she was responsible for the care and rehabilitation of a thousand starving Yugoslavian children. Part of the staff were young Yugoslav women for whom a teaching program as nurse aides was arranged. Early in 1946 Miss Reimer was sent to newly liberated Formosa to assess the status of nursing care and education and to determine the most urgent needs of hospitals and health centres following war damage. Emergency work in a cholera epicemic formed an important part of the program undertaken.

Miss Reimer remained in Formosa during the change over from UNRRA to WHO in 1947-48. Returned to Canada, she became assistant director of nurses at Winnipeg General. Soon the lure of foreign service beckoned her again. Under WHO sponsorship she went to Cambodia as leader of an international nursing education team. A demonstration teaching centre was opened and the broad outlines for a new nursing education program for native women and men was launched.

Miss Reimer's most recent work with WHO — 1953-56 — took her to Egypt where she assisted with the development of a four-year integrated program in basic professional nursing leading to a bachelor's degree, the first university school of nursing in the Middle East.

Norah E. Cunningham is now the regional supervisor of maternal and child health with the Department of Public Health Nursing in Ontario. A graduate from the Vancouver General Hospital with her B.A. Sc. in public health nursing from the University of British Columbia, Miss Cunningham has secured her master's degree from Columbia University and also holds a certificate in nurse-midwifery from the Maternity Centre Association in New York.

After several years as a staff nurse with the Metropolitan Health Committee in Vancouver, Miss Cunningham transferred her activities to the Ontario health services. She became senior staff nurse in the school health services of Haldimand County in 1945, going on to the duties of supervisor of the Huron County Health Unit four years later. Last year she was on the faculty of University of Western Ontario, London, giving part of the course in public health nursing.



HAZEL I. MILLER

Hazel Isobel Miller has assumed the duties of director of nursing at the General Hospital, Kingston, Ont., after five years in a similar position at the Reddy Memorial Hospital, Montreal. After graduation from the Winnipeg General Hospital, Miss Miller engaged in private nursing briefly before going into public health work. She obtained her B.S. degree from Columbia University after which she spent some time with the Winnipeg Department of Health as consultant in tuberculosis nursing, later becoming a district supervisor. In 1947 she was appointed to the national office staff of the Victorian Order of Nurses as a travelling

supervisor. During her last year with the V.O.N. Miss Miller was executive assistant to a commission appointed by the board of governors to make a complete survey of the Victorian Order's activities.

Margaret Jean Dodds, a graduate of Toronto General Hospital is presently the supervisor of nursing service at the new Central Building at T.G.H. Starting in general duty there immediately after she graduated, Miss Dodds has been successively assistant head nurse on a gynecological ward, head nurse in the operating room and for the past seven years, operating room supervisor. She took time out during this latter period to qualify for her diploma in nursing education at the University of Western Ontario. Actively interested in the work of her hospital alumnae association she has served as president for the past two years. Golfing and photography are her principal interests in off duty hours.

C. L. Milne Studios

M. JEAN DODDS

Louise D. Acton, who was on the staff of the Kingston General Hospital for 34 years, the last 16 as director of nurses, retired last June. She will reside in Brockville, Ontario.

A graduate of old St. Luke's Hospital, Ottawa, Miss Acton went to the Kingston General as an instructor in 1924. Under her inspired leadership over these many years the school has steadily increased in size and performance. Her unfailing interest and kindliness have earned her the sincere affection of the hundreds of nurses who developed under her tuition and guidance.

Actively interested in the work of professional nursing organizations, Miss Acton was instrumental in forming District 7 of the RNAO. She served as chairman for eleven years. In addition she has been very interested and active in the Canadian Arthritis and Rheumatism Society as well as the Imperial Order of the Daughters of the Empire. Her many friends wish her long years of good health and happiness.

The Efficiency of a Community

The efficiency of a community will depend on its technical and vocational education; its cohesion and duration will depend largely on its social and political education. But the quality of its civilization depends on something else. It depends on its standards, its sense of values, its idea of what is first rate and what is not. Our knowledge of the sciences, natural or social, fixes the limits of the course within which the yachts on which humanity is embarked must sail, but does not indicate the goal of their voyage, still less supply the wind to fill their sails.

— Sir Richard Livingston

It is never safe to use carbon tetrachloride for cleaning clothes unless the windows are opened wide. It is wiser to use any of the cleaning chemicals outside on the veranda, never in a closed room or basement.

— Dept. of National Health and Welfare

Vegetables, so rich in all the nutrients needed for good health, can be spoiled if they are exposed to sun and air, soaked or cooked too long with too much water, or with carbonate of soda.

— Dept. of National Health and Welfare

In Memoriam

Edna Blainey who graduated from St. Michael's Hospital, Toronto in 1909, died on April 1, 1958. Following postgraduate study and work in the United States, she took special studies in social service work and served with the Ontario Department of Public Health for some time.

* * *

Jenny (Prior) Cope, a graduate of the Brandon General Hospital, died on July 18, 1958.

* * *

Jean (McLaren) Crosbie who graduated from the General Hospital, Montreal in 1930, died on July 21, 1958. Mrs. Crosbie was on the staff of the Jewish General Hospital, Montreal at the time of her death.

* * *

Fanny Dixon, a member of the first class of nurses to graduate from the original Nicholls Hospital, Peterborough, Ont., died on July 3, 1958. She was president of the alumnae association for 25 years and also served as chairman of the Registered Nurses' Association of Ontario when that group was formed from the Graduate Nurses' Association of Ontario. Miss Dixon was 94 years of age.

* * *

Edith A. Dynes, a graduate of the Toronto General Hospital in 1910 died on July 30, 1958 in Burlington, Ont. She had retired from nursing 20 years ago.

* * *

Dorothy Hadrill who graduated from the Montreal General Hospital, died on August 25, 1958. She had engaged in private nursing for much of her professional life.

* * *

Eva Hubman, who graduated from the McKellar General Hospital, Fort William in 1916 died on July 7, 1958. She had been superintendent of nursing of the Fort William Public Health Department for many years.

* * *

Rose Ann (Campbell) Mackay, a graduate of the Misericordia Hospital, Winnipeg in 1929, died, after a lengthy illness, on July 6, 1958.

* * *

Marion Moodie, the first graduate of the General Hospital, Calgary died in March, 1958.

* * *

Ethel Pratt who retired from active nursing in 1934, died on July 30, 1958 in Brockville, Ont. She had been in poor health for many years.

* * *

Jessie Middleton (Sedgewick) Roman who graduated for the Royal Victoria Hospital, Montreal in 1915 died on July 20, 1958. A member of No. 3 Canadian General Hospital (McGill) Contingent in World War I, Mrs. Roman served in France for four years. During World War II she took a very active part in the work of the Red Cross Society.

* * *

Anita Ross, a graduate of the Royal Victoria Hospital, Montreal in 1918, died on August 7, 1958. For many years, Miss Ross was in charge of the department of electrolysis in the Ross Memorial Pavilion.

With the growing concern about the incidence of staphylococcic infections, a recent study, incriminating laundry and refuse chutes as one means of spreading bacteria, is of special interest.

A controlled investigation in a modern 16-story hospital revealed a very considerable movement of air from the laundry and refuse chutes into the hospital corridors, especially on the upper floors. There was a steady leakage of contaminated air, even when the chute doors were closed. Large "gusts" were blown into the corridors if the chute doors were open during the passage of materials down the chute.

The air of the laundry chute contained 200 to 600 staphylococci per cubic foot, and that of the refuse chute up to 100 per cubic foot. Even more alarming was the fact that the majority of chute staphylococci were found to be resistant to penicillin and other commonly used antibiotics.

—*Journal of the American Medical Association*, July, 1958

* * *

Bringing up children is not an unskilled occupation. It may be that the elements of good motherhood for very small children Can be learned easily but there is nothing elementary about the problems of guiding intelligent children into and through their 'teens. Whether such a child has a brilliant career ahead of him depends enormously upon the guidance and influence of parents.

— Dr. Eric Ashby

Thyroid Conditions

MYRL E. SKINNER

THE THYROID GLAND is located in the anterior part of the neck and is composed of two lobes that lie on either side of the trachea and are joined by a narrow band called the isthmus. Thyroxin is the secretion of the thyroid gland. This secretion is high in iodine content and is responsible for the speeding up of metabolism.

An abnormal enlargement of the thyroid is called a goiter. Three types of goiters are seen: 1. Simple Colloid 2. Adenomatous 3. Exophthalmic. The most difficult one to treat is the exophthalmic whereas the one most frequently requiring surgery is the adenomatous type.

Simple Colloid goiter is a diffuse, non-toxic enlargement of the thyroid gland. It is found commonly in certain parts of the world, for example, around the Great Lakes and in Switzerland. It is thought to be due to a lack of iodine in the drinking water in these areas.

An abnormal quantity of the secretion develops, enlarging the gland and causing an enlargement of the neck. This may produce: pressure on the trachea with resultant shortness of breath or pressure on the esophagus causing difficulty in swallowing. These cases can be benefited by medical treatment and seldom need surgical intervention for the removal of the excess gland.

Adenoma of the thyroid is a nodular, non-toxic goiter indicated by a benign tumor that occurs in older adults, more frequently in women. Sometimes the adenoma may take on toxic symptoms or may undergo some malignant change. The best treatment is surgical removal of the greater part of the gland including the tumor.

This goiter is the one most commonly seen on surgical wards at the present time. The patients' complaints are never very alarming, consisting mainly of some slight weight loss and some difficulty in swallowing. They may notice the gradual enlargement as a lump in the neck. The basal metabolism reading shows little variation from normal. Preoperatively there is little preparation needed for these patients. A B.M.R. is often taken and the usual preoperative routine examinations such as urinalysis and hemoglobin estimation should be done. Preoperative sedation the night before helps to ease the patient's fears.

The immediate postoperative care consists of carefully moving the patient from the operating table to bed so as not to extend the neck and cause tension on the sutures. The patient should be placed in semi-Fowler's position to facilitate breathing and should be well sedated to prevent restlessness. Intravenous therapy is sometimes continued from two to twenty-four hours. The dressing should be inspected frequently for any signs of hemorrhage. The average hospital stay is from six to nine days including pre- and postoperative treatment. The drain is removed either on the first or second day and the clips the following day. The patient is allowed out of bed on the third day. A slight elevation of temperature to 100°-101° for two days

In need of surgery

Miss Skinner is assistant head nurse on a women's surgical ward at Toronto East General Hospital.

is not unusual following this surgery.

While these patients run a good postoperative course the nurse must be aware of possible complications. They may consist of:

a. Hemorrhage. This will cause the patient to complain of pressure at the site of the incision.

b. Difficulty on respiration caused by edema of the glottis or by an injury to the recurrent laryngeal nerve during operation. This condition requires immediate tracheotomy.

c. Any voice changes should be noted as that might point to an injury to the recurrent laryngeal nerve.

A typical patient of this type is Mrs. Corry a 43-year-old housewife who noticed a mass on the left side of her neck four or five years ago. This gradually increased in size but caused her no pain or discomfort. She stated she had lost some weight. She had no tremor or increase in appetite. There was no evidence of exophthalmus. The pathology report on the gland removed surgically was that of cystic adenoma of the thyroid. The patient had a six-day stay in the hospital. The drain was removed on the first day, the clips on the third day and the patient allowed out of bed. The temperature did not go over the 100° recorded on the first day. She made an uneventful recovery.

Exophthalmic Goiter or Grave's Disease. This condition is usually found in women who are younger than those who develop adenoma of the thyroid. The symptoms of this condition are:

Rapid pulse 100-120; frequent hot flushes; sweating, even of the hands; eyes are prominent and pushed forward. The patient is highly nervous with marked tremors. Palpitation is present when lying down. Indigestion and diarrhea are also common. There may be some enlargement of the thyroid.

This type of goiter presents a much more difficult nursing problem. Apprehension and nervousness have to be battled continuously. Preoperative care consists of reassurance and absence of as many irritating influences as possible. This requires considerable tact on the part of the nurse.

Radioactive iodine is a recent form of treatment frequently used instead of surgery and is the reason why we see so few thyroidectomies for exophthalmic goiter today.

These patients are treated medically for some time prior to surgery. They are given Propylthiouracil until their hyperthyroidism is controlled. Then they are given iodine for 10 days to two weeks, not longer, before the operation to reduce the vascularity of the gland. Immediate preoperative treatment consists of a good night's rest. The patient is often put to sleep in her own room by means of sodium pentothal and does not realize that the operation is imminent nor is she aware of being taken to the operating room.

Postoperative treatment is the same as for adenoma of the thyroid but a much closer watch over the patient is necessary. There is greater risk of any of the complications with the added danger of acute thyrotoxicosis — the thyroid storm. The following symptoms of this complication may appear soon after the operation:

A marked rise in temperature often as high as 105° to 106°.

A rapid thready pulse, 160 to 200.

Profuse perspiration.

Extreme restlessness.

The surgeon should be notified immediately if any of these symptoms appear as delirium and death may follow in rapid order. Application of cold is the immediate treatment, with ice bags, cold sheets and an oxygen tent. Morphine is given to combat restlessness and intravenous therapy, with Lugol's solution added, is to counteract the loss of fluid.

The convalescence of patients after surgery for toxic goiter is much longer than that for adenoma of the thyroid. The patient may need some time in a nursing home if her own home conditions are such as could retard her progress.

Glaring sunshine is harmful to the sight. It is advisable to wear a hat to shade the eyes. Sunglasses are helpful but they should be prescribed by the eye doctor or optometrist.

— Dept. of National Health and Welfare

For those who are trying to reduce, deep breathing may be added to the program. The greater intake of oxygen burns up waste fats and so helps to reduce the poundage.

— Dept. of National Health and Welfare.

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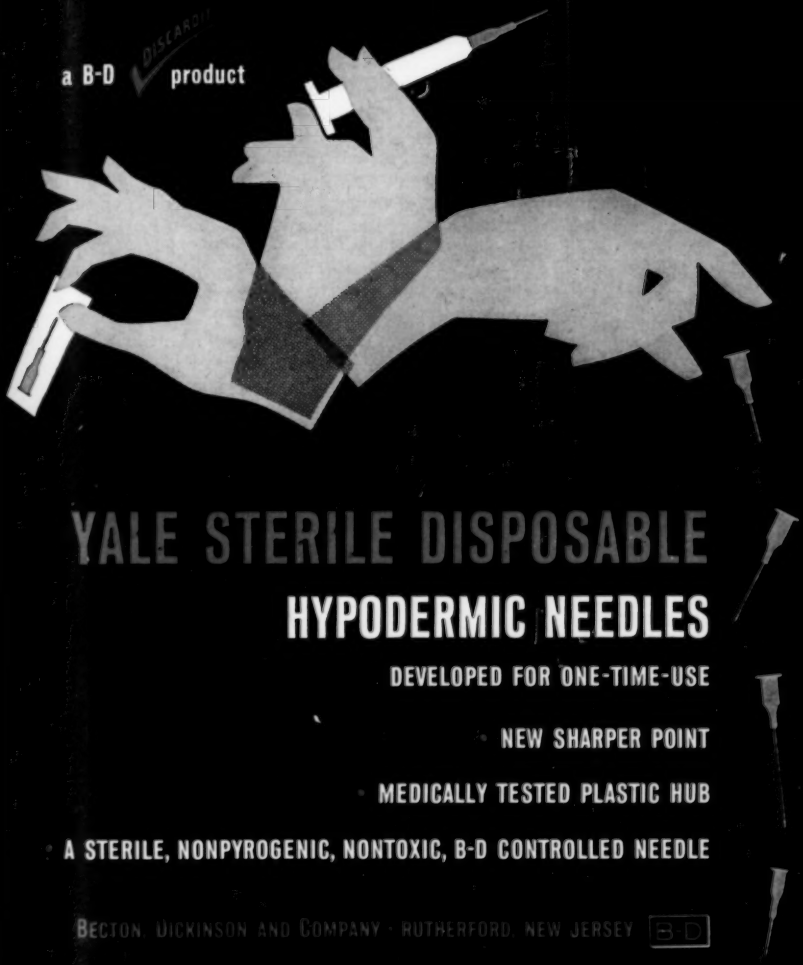

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Le Lévophed

N. Gervais

Les recherches en pharmacologie s'avèrent de nos jours si nombreuses, que l'infirmière doit se tenir constamment en éveil si elle veut suivre la marche des progrès et l'évolution rapide qui se fait dans le domaine médical.

Chaque jour nous apporte de nouveaux produits. L'emploi de certains d'entre eux demande des connaissances essentielles à l'infirmière. Aussi doit-elle apporter beaucoup d'intérêt à se familiariser avec ces nouvelles découvertes afin d'être toujours à la hauteur des exigences de plus en plus nombreuses de sa profession.

Au nombre des agents thérapeutiques récents, il faut mentionner le lévophed.

Le lévophed est une amine primaire que l'on retrouve dans la partie médullaire de la glande surrénale. Il est présenté sur le marché sous forme de bitartrate soluble dans l'eau. La solution à 1/1000 contient par cc. 2 mgm. de bitartrate de lévophed ; soit : 1 mgm. de lévophed base.

Le lévophed agit comme vaso-constricteur général ; il élève la tension artérielle mais sans augmenter sensiblement le débit cardiaque. Il peut donc être employé pour remonter et maintenir la tension artérielle chez les malades en hypotension aiguë dans les chocs consécutifs à une hémorragie grave, à un infarctus du myocarde, à un traumatisme chirurgical ou non chirurgical. On peut également, au cours de sympathectomie lombaire, éviter les chutes de T.A. en administrant un soluté contenant ce médicament.

Il faut savoir que le lévophed doit être injecté par voie I.V. dans 1000 cc. de solution de dextrose à 5% dans une solution saline ou dans 1000 cc. d'une solution de dextrose à 5% dans l'eau distillée. On ajoute à l'un de ces solutés 1 ampoule de 4 cc. de la solution de lévophed à 1/1000 ; chaque cc. contient alors 4 microgrammes de lévophed base. L'administration du soluté doit se faire au rythme de 2 à 3 cc. par minute au début chez les malades en hypotension aiguë. Dès que le traitement est commencé, la T.A. doit être prise et vérifiée aux 2 ou 3 minutes et c'est d'après ce graphique que le débit du soluté sera réglé par la suite. Le malade doit être étroitement surveillé par le médecin durant le traitement et dès que l'on obtient une réponse à la médication, on doit ralentir le rythme de l'injection de façon à administrer ½ à 1 cc. à la minute. Le médecin ou l'infirmière responsable du malade doit continuer à surveiller la T.A. aux 5 minutes ou au besoin selon les résultats obtenus. On ralentit graduellement le soluté puis, on discontinuera dès que la T.A. atteint le niveau désiré. Le médecin peut alors, s'il le juge à propos, garder la veine ouverte à l'aide d'un autre soluté jusqu'à ce que tout danger de récidive soit éliminé.

La durée du traitement dépend de la cause du choc. Cependant dans les cas sévères, on dit que le traitement peut se prolonger jusqu'à 6 jours.

L'emploi de ce médicament n'étant pas sans danger, l'infirmière doit en posséder une connaissance suffisante si elle veut apporter au traitement toute la coopération qu'on est en droit d'attendre d'elle. S'il est nécessaire que le médecin soit auprès du patient au début du traitement ; l'infirmière, elle, ne doit pas pour cela s'en désintéresser.

Il est indispensable de mentionner qu'il est préférable qu'un soluté contenant du lévophed soit administré dans la veine cubitale antérieure ou encore dans la fémorale. Les veines des mains et des pieds doivent être évitées particulièrement chez les vieillards, chez les diabétiques et chez tout malade souffrant d'affections vasculaires. L'aiguille doit être introduite profondément dans la veine et doit être bien fixée afin d'éviter l'infiltration des tissus par ce médicament. Car un écoulement assez prolongé d'un soluté contenant le lévophed en dehors de la

Mlle Gervais est institutrice clinique en médecine à l'Hôpital Notre-Dame, Montréal.

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veine peut occasionner une destruction superficielle des tissus.

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Mais là ne se limite pas la tâche de l'infirmière. Les moindres signes pouvant laisser appréhender des conséquences fâcheuses doivent être communiqués au médecin. Ainsi un mal de tête même bénin, chez le malade, peut être un indice d'une trop forte dose de ce médicament.

Après ces quelques considérations, nous pouvons espérer que nos chers malades bénéficieront d'un nursing encore plus adaptée aux exigences de l'évolution constante de la médecine.

Références: Littérature fournie par la Compagnie Winthrop. Consultation: Dr. J. Gratton, Cardiologue.

Anesthesia for Open Heart Surgery

E. A. Gain, M.D.

Anesthesia for cardiac surgery using extracorporeal circulation presents problems for the anesthetist over and above those usually encountered during cardiac surgery. During and following the actual perfusion, the anesthetist requires other methods than the standard auscultation or palpation to record blood pressure because of the lower flows and vasoconstriction which often occurs. This is provided by intra-arterial pressure tracings. Blood volume replacement is a very difficult task and clinical assessment alone is not enough. Here the intra-arterial and intravenous pressure tracings are relied upon to a large degree.

During the perfusion the anesthetist must know whether the brain is receiving adequate oxygenated blood. For this he depends on the electroencephalograph which, by recording the brain potentials, indicates in seconds any serious lack of oxygen to the brain. This monitoring device is also the most acute and reliable indicator of anesthetic depth, telling the anesthetist long before any clinical signs appear, that the depth or level of anesthesia is increasing or decreasing. This is of vital importance in these cardiac cases as all anesthetic agents are myocardial depressants, and these hearts often have very little reserve. They will not tolerate deep anesthesia or even those levels of anesthesia which would be considered usual in the average patient.

It is the opinion of most anesthetists today that the anesthetic agent used is of secondary importance; *how* it is used is of maximum importance. Everyone uses what is called balanced anesthesia. This means a combination of agents, which includes the premedication, each designed for a specific purpose in order that no one agent will have to be given in overdose to fulfil the requirements of anesthesia: unconsciousness, sensory block, motor block and autonomic block.

Many anesthetists prefer the combination of Pentothal, nitrous oxide, oxygen and muscle relaxant, often adding an intravenous analgesic such as Demerol. More and more anesthetists are turning back to what has been termed "ether analgesia" often combined with a muscle relaxant during certain phases of the procedure. The gaseous and volatile anesthetics are preferred by many because they can be eliminated by the lungs and need not be metabolized by the body. Once an intravenous agent is administered it

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Dr. Gain is head of the Department of Anesthesia at the University Hospital, Edmonton, and clinical professor of Anesthesia at the University of Alberta. In response to requests for information regarding the anesthesia used in performing the open heart surgery described in the article on page 726 of the August issue, Dr. Gain has prepared this statement.

IN ACNE

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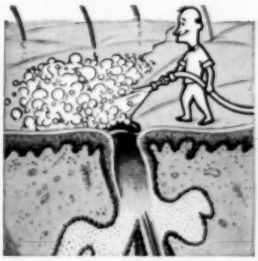

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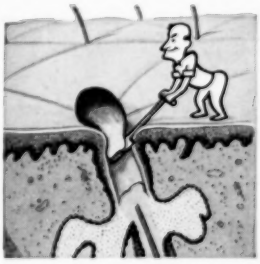

◂ Penetrate and soften comedones, unblocking the pores and facilitating removal of sebum plugs.

Fostex dries and peels the skin

◂ The Sebulytic base of Fostex dries and promotes peeling of the skin . . . actions enhanced by the keratolytic effects of micropulverized sulfur and salicylic acid.

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cannot be removed from the body by the anesthetist as can the volatile liquid and gaseous agents.

During perfusion with the bubble oxygenator, volatile and gaseous agents are "blown-off" in the open oxygenating column. This frequently results in the patient awaking. Then intravenous agents must be used. With other types of oxygenators, volatile agents may be administered to the oxygenator avoiding this complication.

It is of course necessary with a bilateral open chest that the anesthetist "breathe" for the patient at all times. This must be done carefully, avoiding excess of pressure or prolongation of pressure otherwise venous return, cardiac filling and cardiac output will be impaired.

Light anesthesia, perfect ventilation, accurate blood replacement are the essentials for safe anesthesia for cardiac surgery.

Melanotic Sarcoma

JOANNA JENKINSON

SOCIAL BACKGROUND

MRS. ALLAN, 37 years old, was admitted with the tentative diagnosis of a "slight stroke." By occupation, she was a clerk employed by a local chain store. She is one of four siblings, the other three being, at present, alive and well. Her mother is alive and well. Her father died (aged 65) of meningitis. Mrs. Allan's personal history is somewhat sad in that after five months of marriage her husband deserted her. Then, two years ago, she gave birth to an illegitimate baby which was given up for adoption. At the time of her admission, she was living alone with her mother.

MEDICAL BACKGROUND

Mrs. Allan had the usual children's diseases. With the following exceptions, up until her present illness, her medical history was negative:

1. A nervous breakdown that had resulted from her husband's departure.
2. Spontaneous passing of kidney stones in 1955.
3. Bronchitis of six weeks' duration.

PRESENT COMPLAINTS

On admission, Mrs. Allan's complaints were typical of her initial diagnosis — a slight stroke. She had generalized weakness of the right side of her body, and slurred speech. She also complained of some back pain.

PHYSICAL EXAMINATION

A complete physical examination was done, both by the intern and the consulting physician. The following findings were made:

1. Weight 130 lb.
2. Blood pressure 130/70
3. Slurred speech
4. Absence of generalized pinprick sensation
5. Very pale skin
6. Some splinter hemorrhage under fingernails
7. Weakness on right side of body
8. Paresis of the mandibular branch of the seventh cranial nerve

It is well to note that —

1. Glands were negative
2. Fundi of the eyes were negative
3. There was no enlargement of the liver or spleen, nor were any masses felt in the abdomen at the time of this examination.

FUNCTIONAL ENQUIRY

Mrs. Allan's speech was slurred but she was able to give the following information:

1. Before admission, she had suffered from a left-sided headache.
2. She had had occasional palpitation.

Miss Jenkinson is a graduate of St. Joseph's Hospital, Victoria, B.C.

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3. She had noticed some dyspnea on exertion.

4. Her appetite had been poor; she had some weight loss and occasional attacks of epigastric pain that disappeared after eating.

5. Bowels were regular, and no melena had been present.

6. Menstrual periods were regular and normal.

Diagnostic Procedures

During her first few days of hospitalization, Mrs. Allan had many tests done in an effort to make a definite diagnosis. These included:

1. *Lumbar puncture.* The specimen of fluid obtained was tested for:

Blood cells ..... Negative.
Protein ..... Negative.
Evidence of C.N.S. Syphilis
Kahn ..... Negative.
Colloidal gold ..... Negative.

(Note: An increase in protein content of the fluid would have been indicative of a meningeal infection.)

The spinal fluid pressure was found to be within normal limits.

2. *Benzidine test* for occult blood in the feces was negative.

3. *Hematology:*

	Normal	*Mrs. Allan*
Hemoglobin	12-16 Gm.%	11.1 Gm.%
Red blood cells	5 million	4.08 million
White blood cells	5-9,000	7,450
Platelets	250,000-500,000	121,000
Bleeding time	1-3 min.	2.5 min.
Clotting time	5-10 min.	9 min.
Sedimentation rate	20 mm/hr.	37 mm/hr.
Mean Corpuscular Volume (M.C.V.)	80-94	97 cells per cubic micron
Mean Corpuscular Hbg. Concentration (M.C.H.C.)	32-38%	28%
Prothrombin	80-100%	24%

From the hematology report, the following had to be taken into consideration:

a. Low hemoglobin, red blood count and M.C.H.C. are indicative of anemia.

b. Normal white blood count was a good indication that there was no infection present.

c. Low platelet count could be indicative of bacterial endocarditis or purpura hemorrhagica.

d. The sedimentation rate is increased in conditions of tissue destruction, e.g., malignancy, rheumatic carditis, internal hemorrhage.

4. Electrocardiogram showed abnormal tracings characteristic of toxic myocarditis.

5. Routine urinalysis was normal.

6. *X-ray investigation:*

a. A-P film of chest — Diaphragm was normal; lung fields were clear; cardiac shadows slightly enlarged.

b. A-P and lateral films of spine — The outline of the sixth dorsal vertebral body was somewhat indistinct and there was some reason to suspect that there had been some collapse of its upper surface. The third lumbar intervertebral space was considerably narrowed and the anterior margins of the vertebral bodies contiguous to this space had a bulging appearance. The spine tilted slightly to the left on the sacrum.

Diagnosis

With so many negative reports to counteract any diagnosis previously thought possible, the consultant physician suggested hysteria as the basis of Mrs. Allan's complaint. The intern on the other hand, still thought of a slight stroke, and possibly an ulcer.

Progress of Case

Mrs. Allan was placed on general medical care. A light diet was ordered. This consisted of soft foods with little bulk, which made it easier for her to swallow and to digest them. For the most part, Mrs. Allan had to have her nurse's help at mealtime.

She was on bed rest with bathroom privileges. While up, however, she complained constantly of back pain, and consequently spent most of her time in bed. Because of this, she was given good back care to prevent the possibility of any pressure sores developing.

Empirin tablets were ordered q.i.d. Empirin contains codeine (an alkaloid of opium with an analgesic action), caffeine (a C.N.S. stimulant that is added to the medication to counteract the depressant action of the codeine), aspirin (an analgesic antipyretic derived from coal tar), and phenacetin (also an analgesic antipyretic derived from coal tar). This was ordered to relieve pain. Phenobarbital gr. 1 was

ordered t.i.d. In this case it was given to relieve any nervous excitability or mental anxiety that may have been present. Chloral hydrate gr. 7½ was ordered h.s. Chloral hydrate depresses both sensory and motor areas of the brain. It is used in cases of nervous insomnia.

For a few days, Mrs. Allan was not swallowing saliva, and seemed to be constantly drooling. Because of this, special oral care was given. Her mouth was not dry, so only Glycothymoline was employed for this. She did very little talking, so her nurse was required to anticipate her needs.

She voided involuntarily. To prevent any harm to her back, the bed had to be changed frequently and again, back care was important, Then, at the other extreme, there were times when catheterization had to be resorted to. This was done under sterile technique to prevent entry of any infection to the urinary tract. Her urine was dark and concentrated. Her bowels were not functioning efficiently, and after several doses of Magnolax, an enema was given.

Twelve days after admission Mrs. Allan developed jaundice. An icterus index revealed 18.1 units of bilirubin per 100 cc. of blood; the normal for this test is only 2-5.5 units. The urine was tested for bile pigments and the results of this test were highly positive. Bilirubin level in the blood is increased in intrahepatic biliary obstruction, e.g., malignant tumors, and also in concealed hemorrhage. Bilirubinuria is a sign of obstructive jaundice. The urinalysis also revealed 40-50 red blood cells. A blood culture done at this time was negative.

Mrs. Allan's condition, meanwhile, did not improve. It only appeared to become more grave.

A repeat consultation was done, at which time it was stated that:

> The patient obviously does not have an hysterical basis for her symptoms. Since seen a week ago, the paralysis in her face and the neurological signs in her arm and leg have recovered but she still has outgoing Babinski responses. Yesterday she developed jaundice. Complete re-examination today reveals the following findings:
>
> 1. She looks sicker — her mind is unclear.

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2. She is definitely jaundiced — obstructive in type.

3. Her fingernails show some fresh splinter hemorrhages and inside her mouth there are numerous purpura on an inflamed mucous membrane.

4. Eye grounds are still normal.

5. There are no murmurs in the heart — the spleen is not enlarged.

6. Blood pressure and lungs are normal.

7. The abdomen is a little more distended. The liver is enlarged one finger's breadth but does not appear to be tender.

8. Rumple-Leede's test negative. Constriction is applied to the arm. If petechiae appear, the result is positive.

9. There are numerous r.b.c. in the urine, and she is running a low grade fever.

10. Platelet count is low.

11. She is having much pain from the flexure of the back.

12. Her breasts were carefully examined and there is no sign of carcinoma. There is no generalized lymphadenopathy.

Differential Diagnosis

1. Subacute bacterial endocarditis. (No high fever, no heart murmur, no splenic enlargement.)

2. Multiple emboli from another cause such as

a. Carcinoma with secondary metastases in the liver (no primary lesion can be found.)

b. Diffuse lupus erythematosus.

c. Thrombasthenia.

The following tests were ordered:

A blood culture that proved to be negative.

A platelet count that proved to be normal (320,000).

A urinalysis, which showed 90-100 red blood cells.

A sedimentation rate that revealed an increase at 37 mm./hr.

A large chest plate was done. The only change from the last report was the presence of two small foci of segmental atelectasis in the lower left lung field.

While awaiting the blood culture reports, penicillin therapy was started as a prophylactic measure, in view of the possibility of bacterial endocarditis. It is most interesting to note the way in which this order was put on the doctor's order sheet. "Give a test dose of 100,000 units of aqueous penicillin, then Benadryl 50 mgm. I.M., stat. If any reaction, give adrenalin 1:1000 5 minims s.c., — have this on hand!"

The Benadryl was given to prevent any reaction that might have occurred from the administration of the penicillin. In the event that Mrs. Allan was highly sensitive to the penicillin, and developed an anaphylactic shock, the adrenalin would have acted as a bronchodilator, and respiratory stimulant. A slight rash was the only reaction.

On the 15th day hard, enlarged glands were detected in the right side of her neck. The next day Mrs. Allan seemed much worse. The liver had enlarged four finger's breadth. The consultant physician suggested that both of these could be signs of carcinoma or sarcoma metastases, but still could find no primary lesion.

No definite diagnosis had yet been reached. It was decided to do a biopsy examination of the enlarged glands in the neck in an effort to reach one. Mrs. Allan was booked for surgery.

Nembutal gr. 1½ was given h.s. the night before. Demerol 100 mgm. and hyoscine gr. 1/150 were given one hour preoperatively. Demerol depresses the sensory and psychic areas of the cerebrum. Its actions and uses are similar to those of morphine. Hyoscine decreases the secretion of saliva and mucus in the nose, pharynx and bronchi, thus reducing the hazard of aspiration.

In the operating room, the patient was given intravenous demerol to aid in relaxation. Local infiltration was carried out with 1 per cent novocaine and a little adrenalin around the tumor mass. Novocaine is the most widely used and probably the safest of all local anesthetic agents. It is destroyed rapidly in the body and is non-irritating to the tissues in 1-2 per cent solutions. A round irregular, grayish-brown lymph node was dissected from beneath the sternocleidomastoid muscle. The incision was sutured, and a small Penrose drain left in.

From this biopsy, the conclusion was reached that Mrs. Allan was suffering from melanotic sarcoma.

Definition of Condition

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nevus, the simple melanoma occurs most commonly on the skin, but is also found in the eye, in the meninges and in the adrenal medulla.

Malignant melanomas (melanotic sarcoma) arise most frequently from the choroid of the eye and from the skin but occasionally they originate in the internal organs such as the brain or adrenals. This is one of the most malignant of all neoplasms as is shown by the widespread distribution of the metastases and the early date at which they occur. Characteristic of melanotic metastases is the presence in the cells of the brown melanin pigment. At an early date it invades the lymphatics and blood stream and may ultimately lead to involvement of practically every organ in the body.

The great majority of tumors arise from a pre-existing pigmented mole, usually one which has been subject to chronic irritation. It is of prime importance to recognize the signs indicating that a mole is changing into a melanoma. These are: a sudden increase in size and vascularity; darkening in color; superficial ulceration and bleeding. It is usually metastatic nodules in the skin that first attract clinical attention, and with their existence, a primary lesion in the shape of a pigmented mole is usually looked for on the skin or in the eye.

It may be that no primary lesion or tumor is found either on the skin or in the eye. The primary tumor may be in the brain or in the adrenal medulla where melanoma are also found. Cerebral tumors arise from the pigmented cells of the pia mater. Finally, there is an obscure group of cases where no primary tumor can be found either clinically or at autopsy.

Summary

Two weeks following surgery, Mrs. Allan succumbed to the disease. True to form with many cases of carcinoma and sarcona, the primary symptoms she displayed tended to point to the diagnosis, "a slight stroke."

Reviewing the anatomic findings at post-mortem examination however, the cause of all the symptoms displayed in this case is readily explained. The examination made no mention of a primary focus, but revealed metastatic melanotic sarcoma grade iv of stomach, pancreas, lungs, right and left adrenals, right and left kidneys, mesentery, pericardium, esophagus, lymph nodes generally and the brain. This is a classical picture of melanotic sarcoma.

Conclusion

It is sad indeed to think that anyone as young as Mrs. Allan was a terminal cancer case. It makes one hope that all the research being done on the disease will sometime, very soon, end in a cure. At present, the best we can hope to do as nurses, is to urge everyone with whom we come in contact to have regular medical check-ups, and to advise their physician at the earliest possible date of:

1. Any change in bowel habits
2. Any unnatural bleeding from any body opening
3. The enlargement or change in any way of a mole or birthmark.

Large numbers of people continue in gainful employment beyond their 65th birthdays. In March of last year more than half of the male population in the age group of 65-69 was still in the labor force; even at ages 70-74, the proportion was practically two-fifths, but at ages 75 and over it was only one-sixth. The proportion of women in the labor force at the older ages is much lower.

The majority of older employed persons work full time, the proportion of full-time workers being two thirds for the men and more than half for the women. — Metropolitan Information Service

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Nurses and New Parents

ESTHER J. ROBERTSON, B.S.

TODAY AS NEVER BEFORE, nurses are facing a challenge in their increasing responsibilities for maternal and newborn care. Are we, as nurses, meeting this challenge with insight, understanding and technical skill? Have we a wise and sympathetic approach as we help mothers and fathers assume the responsibilities of parenthood? Are we able to provide parents with the information they want and need to safeguard their own health and the health of their babies?

Nursing responsibilities for maternal and newborn care are many and varied. They require not only the application of technical knowledge and skills but also the use of supervisory, counselling and teaching skills. Health teaching and counselling have become important adjuncts to obstetrical nursing. The nurse as a member of the health team, assists the family maintain positive health. She is one of the persons on whom parents may rely for help in preventing or solving health, social and economic problems related to the family's well-being.

Today more people recognize the need for health knowledge to prepare them for the demands of daily living. More printed health education materials are available through departments of health and more articles on health matters are appearing in popular publications. Some health articles in magazines and newspapers are good and other are poor, but because of the good and the bad we have an alerted public. Certainly through reading, listening to the radio and watching television, individuals have become more aware of the relationship of health to success and happiness. In many communities parents, prospective parents and young people are voicing their need for information and guidance. Therefore, we find an increased interest in and demand for community facilities which will provide them with the necessary health knowledge. In many communities expectant mothers and fathers too, are attending prenatal classes. Community libraries report extensive use of books on prenatal care, parenthood and child care and development. Personnel in public health and hospital services are constantly being asked to answer questions on health matters.

ESTHER J. ROBERTSON

There is a much deeper understanding of fundamental human needs. There is an increased emphasis on the science of human behavior and on the techniques of understanding and working with individuals and families. Doctors and nurses are being taught to think of the psychological as well as the physical aspects of living. They are encouraged to work with people as individuals, as members of a family and of a community. We know that each individual is different. Each family is different. Each community is different. Past experience, present health knowledge and family circumstances all have their influence. They all have to be taken into consideration as we plan health teaching and counselling services in the communities in which we work.

The nurse's opportunities for health teaching and counselling will vary with her work situation. For example,

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Miss Robertson is Nursing Consultant in the Division of Child and Maternal Health, Department of National Health and Welfare, Ottawa.

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*Benson, R. A., and associates. J. Pediat, 34:49, 1949
Klarmann, E. G., and Wright, E. S., Soap San. Chem. 22:125, 1946

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some of the public health nurse's opportunities for meeting individuals and families occur during the prenatal and postnatal periods. The hospital nurse has more opportunity to be of assistance to mothers during labor and the early postnatal period. The nurse's teaching and counselling techniques will require adjusting, to meet the interest and learning capacity of each individual and family. We may work with the uninformed, the highly educated, the receptive, the antagonistic or the very passive. Each type of individual is a challenge to our resourcefulness and to our teaching ability. Backgrounds and attitudes influence teaching methods.

Even with variations, the starting point is the same for every opportunity for health teaching or counselling. To express it simply, the starting point is: to determine first what the individual *wants* to know and then what he or she *needs* to know. We know from experience that the information wanted and that which we feel is needed may not be the same. For example, most individuals recognize their need for knowledge in relation to the prevention of disease and many of them want information on specific health problems. However, fewer individuals recognize their need for knowledge in relation to the maintenance of optimum health including mental and emotional well-being. Nurses can help parents to recognize these broader basic health needs as they work with them during the maternity cycle. Most parents at this time are extremely receptive.

Whatever the type of individual, whatever the method of teaching, it is important to take into consideration the four "R's" which underwrite the learning process. These are — readiness, relationship, review and response. *Readiness* indicates a desire for knowledge; in other words, information is wanted. *Relationship* means relating new information to that which is familiar but which needs expanding. *Review* includes using frequent opportunities for recall of information with periodic repetition as indicated. *Response* results from successful health teaching, since our ultimate goal is the application of health knowledge to daily life.

The conscious recognition of the value of these four "R's" to successful health teaching is most essential. If subject matter is planned to relate new material to that which is familiar and if it is also planned to arouse interest, we can help parents develop a desire for further knowledge and a will to apply that knowledge to daily life. It is our responsibility to plan, adjust, revise and evaluate our subject matter in the light of individual or family response, as well as in the light of scientific development and new facts.

Prenatal care, that is health supervision and health teaching during the prenatal period, is perhaps the most important aspect of maternal and newborn care. Good prenatal care forms the basis for good family health. Most prospective parents want to know what to do, why they should do it and how they can do it. Knowing what they should do is not enough. Why and how to do it are just as important. We can not expect parents to adjust or revise their present living habits unless they themselves see the advantage of or need for adjustment.

By observing, by skillful questioning, by attentive listening, by providing information and making suggestions, doctors and nurses working together can help parents plan for good prenatal care, that is, adequate prenatal medical supervision, adequate nutrition, rest, comfort and freedom from worry. However, doctors and nurses can only make this contribution if parents recognize health needs and seek assistance.

The public health nurse is in a key position to interpret the imporatnce of *medical supervision* during pregnancy. As the nurse interprets the need for medical supervision, special emphasis on the mother's own health as it affects her baby and her family is a strong teaching point. Many mothers who are casual about their own health are anxious to maintain the health of the children in the family. The unborn baby is a future member of the family. Good prenatal medical supervision influences the health status of the mother and her baby.

Helping parents plan for *adequate nutrition* is becoming more and more a responsibility assumed by nurses.

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Nutritional research, relating the mother's prenatal diet to the outcome of her pregnancy and to the condition of her baby, has been carried out by scientific investigators in many countries. Research reports show a relationship between the nutrition of the mother, complications of pregnancy and the condition and development of the baby. It has been found that good nutrition before and during the prenatal period is a safeguard for the health of both mother and baby.

How can nurses help parents plan to obtain an adequate diet for the expectant mother and the family? To do effective nutrition teaching we need to know the foods essential for health, the elements these foods provide, why they are necessary for health and how they might be included in the daily diet. It may take considerable tact and resourcefulness to help an expectant mother see that her diet, which to her may seem unrelated to her own or to her baby's welfare, will actually increase their potentialities for maximum health. We know that during pregnancy there is not only rapid growth of the mother's tissues but also growth and development of the baby from a single cell to over 200 billion cells that make up the human body. Understanding this growth process will help the mother see the importance of including the right foods in her diet.

We must remember that all adults have established food habits. Economic status, food likes and dislikes, nationality, religion and social environment are factors which influence an individual's diet. To change habits of long standing is usually a slow process. If change is necessary it may appear to be too dificult for a mother who has neither the time nor the ability to think of herself. Most mothers need a simple explanation of what foods are necessary and why they are considered essential. Changes in eating habits can only be brought about with complete understanding of why the suggested change is considered necessary.

Our nutrition teaching, as all our health teaching, must be sound, clear and applicable to the family situation. Our ultimate goal is to present the facts so that good nutrition becomes everyday practice for the whole family.

Preparation for parenthood is an experience shared by husband and wife. Each needs to understand and be able to help and support the other. Childbearing is a normal physiological process, not a morbidity condition, as some are prone to think. Usually pregnant women are well. If expectant parents know and understand the physical and emotional changes which normally occur during pregnancy, adjustments to these changes can be made more readily. Many of the so-called discomforts of pregnancy are merely the results of normal anatomical and physiological changes which occur as the woman's body reacts and adjusts to the growth and development of the baby in the uterus.

The well-informed mother who receives sympathetic and careful supervision, an adequate diet, sufficient rest and relaxation will adjust well to her pregnancy. If she maintains a close contact with her doctor, knows what to report to him, has an understanding of the process of labor and delivery and has some knowledge of hospital procedure, worries and anxiety, so common during the prenatal period, will lessen.

A well-informed father becomes an understanding sympathetic partner. He usually wants to help plan for the well-being of his wife and the coming baby. He will want to help but it is important for him to know that his help is necessary and that it is appreciated. Father is a key person in the family group. His wife needs his love, understanding and sympathy. His children depend on his energy, his maturity, his ambition and on his ability to provide for their physical, mental and emotional needs.

Most fathers have some anxieties in relation to pregnancy and to the resulting responsibilities of parenthood. There may be the worry of additional expenses for medical care and hospitalization or for equipment and clothing for the baby. Some fathers will worry about the increased future budget for food and shelter for an additional family member. Perhaps the greatest fear of all is the fear of losing his wife. Most fathers think of these matters. They worry and fret but try to work out a plan

. . . mothers, too, seem to have more confidence in Drapolex. It is smooth, soothing, and quick to relieve distress. And certainly, because it was evolved specifically for the treatment and prevention of diaper rash. Drapolex evokes a highly satisfactory response in even the most severe cases. Furthermore, the benzalkonium chloride is effective against a wide range of pathogens which might create a secondary infection as well as against the urea splitting organisms causative of diaper rash. The effectiveness of Drapolex has resulted in its use and recommendation by numerous paediatricians, an effectiveness found also in the treatment of urinary dermatitis through senile incontinence and genito-urinary conditions. Easy to apply, Drapolex . . .

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to overcome their anticipated difficulties. Public health or hospital nurses can help if they take time to listen sympathetically for an expression of these fears.

Parents assuming responsibilities for a *first* child require considerable assistance as they prepare for and learn to take care of their baby. Many unhappy hours could be avoided if each new mother learnt how to handle a baby before her baby was born or before she brought her baby home. Nurses, especially those in hospitals, can provide new mothers with a feeling of security and self-assurance if they teach the simple fundamentals of child care. It is important that each mother knows how to lift and handle her baby, how to change him, how to bathe him and, most important of all, how to feed him. Not knowing what to do or how to do it causes anxiety or stress.

Doctors and nurses can do much to overcome anxieties and to relieve stress by giving up-to-date information and reassurance. Sometimes just having the opportunity to express their fears will help parents overcome them. Most fathers and mothers are very conscious of their responsibilities for parenthood but, often, concern that they will not be able to provide good care interferes with their enjoyment of their child. Ours is the responsibility to supply information so that it becomes real and vital to them. If we present the facts in such a way that parents will want to apply them in their lives, then we are doing effective teaching. When a father and a mother know that certain facts or certain information is related to their future, their baby and their family, they usually are ready and willing to put that knowledge into practice.

Expert medical and nursing supervision takes into consideration the emotional as well as the physical aspects of maternity and newborn care. It is not enough to keep mothers and babies alive by providing for a safe delivery and an uncomplicated postpartum period. Doctors and nurses can help families maintain positive health. Are we as nurses doing all we can to provide parents with the health knowledge so necessary for present day living? Are student nurses being prepared to assume their responsibility for health teaching and counselling related to maternal and child health?

July to October are the worst months for hurricanes for residents along the Atlantic and Gulf coasts. In the past, some of these disturbances have reached into Canada. The Canadian Red Cross Society has issued a series of ten safety tips for persons who may find themselves in the path of hurricanes in Canada or while touring in the United States.

1. Read newspapers and listen to radio and television stations for official weather bureau hurricane reports.

2. Store garden furniture, tools, awnings and other loose objects in a safe place. Such items could become lethal weapons in a storm.

3. Board up windows and put storm shutters into place.

4 If you are told to evacuate, don't delay. Just get out and follow instructions — a minute could save your life.

5. Don't run the risk of being marooned. Get away and stay from low-lying land, beaches or other places likely to be swept by high winds and tides.

6. Don't go outside during the storm. Stay indoors, preferably in a brick or concrete building.

7. Stay away from windows.

8. If the centre or "eye" of the storm passes directly overhead, there will be a deceptive lull, lasting for as long as 30 minutes. Stay where you are during this calm period. The wind will return from the opposite direction, perhaps with greater force.

9. Fill bathtub, bottles and cooking utensils with water. Keep extra food (which does not require cooking) handy. Be sure to have a flashlight or candles handy to use in the event of power failure.

10. Don't touch fallen wires. Report such damage to police or power companies.

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for its wholesomeness, its
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PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Kellogg Supports New School

The W. K. Kellogg Foundation of Battle Creek, Michigan, has promised its support to establish a School of Nursing at the University of New Brunswick.

The Foundation has offered a commitment of $250,000 to be spread over a period of eight years to help in organizing and operating the school. The new school will offer a four-year degree course in nursing, thus supplementing the present system of nursing education in New Brunswick.

Provision is made in the grant for the staff of the school of nursing to be available as consultants to the government and to hospitals and to aid in the program of continuing education for nurses now being carried on under the auspices of the New Brunswick Association of Registered Nurses.

Congratulations to the executive and members of the NBARN who have worked so untiringly to bring about this generous assistance from the Kellogg Foundation.

Katherine MacLaggan, former Chairman of the C.N.A. Nursing Education Committee during the last biennium has assumed her new duties as director in September of this year. Her task for the first year will include the innumerable details of setting up and organizing the new school. It is expected that the first class will commence in September 1959.

All nurses will want to join in offering Miss MacLaggan congratulations and best wishes in this exciting new project.

CNA Anniversary Spoons

Have you seen the attractive sterling silver coffee spoons bearing the new CNA Crest that were available at the 50th Anniversary meeting in June? The Crest is depicted in color and the entire effect is most attractive. If you are starting a collection of coffee spoons, here's the place to start. Each nurse will want one, even our collector friends will be interested.

Proceeds from the sale of these spoons will go towards the fund for the Pilot Project for the Evaluation of Schools of Nursing. Cost of the spoons is $2.50 each.

You may place your order by writing to the Canadian Nurses' Association.

Photographs of Cavalcade in White

Amateur photographers were busy taking photographs during the Pageant. If you were successful in obtaining a good picture of any scene of Cavalcade in White, National Office would like to receive a copy. Your assistance in adding to our collection of photographs for the CNA Archives will be much appreciated. Please send pictures to Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa, Ontario.

The RNAO Adopts a Policy of Voluntary Negotiation

The Registered Nurses' Association of Ontario at its annual meeting in April, 1958, adopted a policy of voluntary negotiation with employers on behalf of all registered nurses with the ultimate aim of securing legislation for compulsory arbitration if necessary. This policy was adopted following a presentation and discussion of three plans for collective bargaining :—

A nurse's busy day frequently leads to inadequate nutrition...

for prevention or correction of vitamin deficiency...

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VITAMINS B with C and D

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1. Certification under the Labor Relations Act
2. Special legislation
3. Voluntary RNAO Personnel Relations program.

Mrs. **Margaret Strong**, who has been assistant registrar with the RNAO was appointed Consultant in Personnel Relations and has been given special preparation in readiness for the initiation of a Personnel Relations Program. Canadian nurses will follow the development of this program with interest.

Le Nursing à travers le pays

Donation de la Fondation Kellogg en faveur d'une nouvelle école

La Fondation W. K. Kellogg de Battle Creek, Michigan, a promis son aide pour l'établissement d'une école d'infirmières à l'Université du Nouveau-Brunswick.

La Fondation s'est engagée à verser la somme de $250,000.00 répartie sur une période de huit ans pour aider à organiser et à faire fonctionner l'école. Cette nouvelle école donnera un cours de quatre ans conduisant au baccalauréat, venant ainsi compléter le système d'éducation en nursing dans la province du Nouveau-Brunswick.

Avec le versement de cet octroi, il est stipulé que le personnel de l'école sera à la disposition du gouvernement et des hôpitaux à titre de consultant et pour apporter son concours au programme d'éducation des infirmières actuellement poursuivi sous les auspices de l'Association des Infirmières du Nouveau-Brunswick.

Nos félicitations au Comité de Régie et aux membres de l'Association des Infirmières du Nouveau-Brunswick qui ont travaillé sans relâche pour obtenir cette généreuse aide de la Fondation Kellogg.

Mlle **Katherine MacLaggan**, convocatrice du Comité de l'Education en Nursing de l'A.I.C. durant la dernière période biennale, a été nommée directrice de l'Ecole d'infirmière de l'Université du Nouveau-Brunswick. Elle entrera en fonctions en septembre, et verra à l'organisation de cette nouvelle école qui ouvrira probablement ses portes au mois de septembre 1959.

Toutes les infirmières canadiennes voudront se joindre à nous pour offrir à Mlle MacLaggan leurs félicitations et leurs voeux de succès.

La R.N.A.O. se fait agent négociateur

L'Association des Infirmières enregistrées d'Ontario, au cours de son assemblée annuelle tenue en avril 1958, a adopté comme ligne de conduite d'agir comme agent négociateur, libre auprès des employeurs, en faveur de toutes les infirmières enregistrées, entrevoyant la possibilité d'en venir finalement à l'établissement d'une législation pour l'arbitrage obligatoire, en cas de besoin. Cette décision a été prise à la suite de la présentation et de la discussion de trois modes d'entente collective.

1. Certification, conformément à la Loi des Relations Ouvrières.
2. Législation spéciale.
3. Programme librement consenti de Relations du Personnel de R.N.A.O.

Mme **Margaret Strong**, qui a été registraire adjointe de la RNAO a été nommée consultante en relations du personnel; elle a préalablement reçu une préparation spéciale pour l'inauguration de ce programme des relations du personnel. Les infirmières canadiennes en suivront avec intérêt les progrès.

Photographies de "Cavalcade in White"

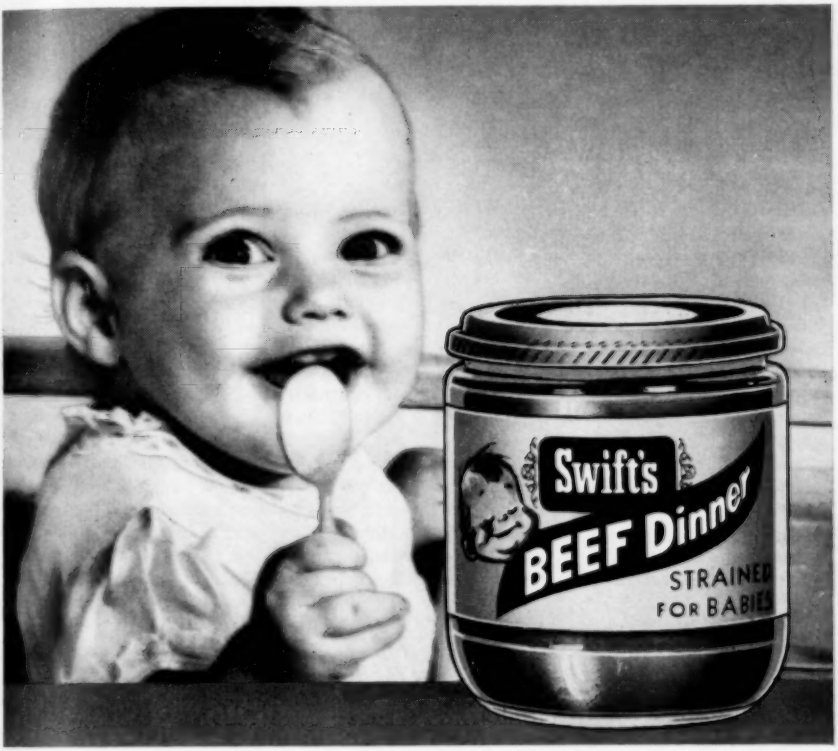
Beaucoup de photographes amateurs ont pris des photos durant le spectacle historique. Si vous êtes de ce nombre et que les photos sont bien réussies, particulièrement des scènes de "Cavalcade in White", votre Secrétariat National serait heureux d'en recevoir un exemplaire. Votre concours sera très apprécié et nous permettra d'enrichir la collection de photographies de nos archives. Prière d'adresser les photos à L'Association des Infirmières Canadiennes, 270 ouest, avenue Laurier, Ottawa, Ont.

Cuillers-souvenir du 50ième anniversaire de l'A.I.C.

Avez-vous vu les jolies cuillers à café, en argent, portant le nouvel écusson de

NOW... the finest Meat Dinners **in sparkling glass**

FROM SWIFT—WHO BROUGHT YOU THE FINEST IN 100% MEATS FOR BABIES!



Swift—meat specialists and pioneers in working with doctors to make meats available in baby foods—now bring you 5 new Meat Dinners . . . in sparkling glass. Swift's Meats for Babies—always the most complete line—is now more complete than ever! These 5 new Meat Dinners have the same smooth texture, are prepared from the same fine, lean meats used in Swift's 100% Meats for Babies. Just the right amount of fresh vegetables and cereal have been included to make them *balanced* dinners.

With the 5 new varieties of Meat Dinners, the 13 varieties of 100% Meats (including 3 fruit-flavoured ones), plus Egg Yolks, and Egg Yolks & Bacon, you can recommend whatever meat best suits each baby's nutritional requirements with the knowledge that *every* meat is available in Swift's complete line of Meats for Babies.

(If Swift's new Meat Dinners are not in your area yet, they will be very soon.)

FOR YOUR CONVENIENCE, HERE IS A LIST OF ALL SWIFT'S MEATS FOR BABIES. (Most are also available in chopped form for older babies.)

Beef • Lamb • Pork • Veal • Chicken • Chicken & Veal • Ham • Liver • Liver & Bacon • Beef Heart • Pork with Applesauce • Ham with Raisin Sauce • Lamb with Mint flavour • Egg Yolks • Egg Yolks & Bacon

Beef Dinners • Chicken Dinners • Veal Dinners • Lamb Dinners • Ham Dinners

Swift

To Serve Your Family Better

l'A.I.C. et que l'on pouvait se procurer au Congrès biennal de juin dernier? L'écusson y est reproduit en couleur et est d'un très bel effet. Si vous désirez collectionner des cuillers, voilà une belle occasion. Chaque infirmière aimera posséder une de ces jolies cuillers et peut-être vos amies aimeraient-elles l'ajouter à leur collection.

Les bénéfices réalisés de la vente de ces cuillers, dont le prix est de $2.50 chacune, seront versés au fonds de l'Etude-Evaluation des Ecoles d'Infirmières.

Vous pouvez les obtenir en écrivant à L'Association des Infirmières Canadiennes.

Books and Pamphlets

The following books and pamphlets have been received in the *Journal* office:

The Advancement of Medical Research and Education. U.S. Department of Health, Education and Welfare. 82 pages. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 1958 Price 60 cents. This is the report presented by a group of consultants who were requested to investigate the activities of the Department in the fields of medical research and education, to estimate national needs and the personnel available for projects in the same fields, to determine standards of approval for research projects and the relationship between Federal and private research programs.

* * *

Report on the Personnel Information Survey, 1956. Registered Nurses' Association of Ontario, 33 Price St., Toronto. 114 pages. In 1956 the RNAO, in annual convention, approved a motion to obtain the services of an expert to survey existing personnel policies for nurses including salaries and hours of work as compared to professional and other groups. This booklet presents the information obtained in a tabular form.

* * *

Selected Experiments in Medical Microbiology by Stewart M. Brooks, M.S. 79 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 1958. Price $2.00. This is a work manual designed for instructors or students. Suggested experiments are basic, simple and in a sequence planned to provide a bird's-eye view of laboratory work.

* * *

Nursing Emotionally Disturbed Patients by Doreen Weddell, S.R.N., Matron, and senior members of the nursing staff, The Cassel Hospital, Richmond, Surrey. 12 pages. Reprinted from the *Nursing Times*. The Macmillan Company of Canada, 70 Bond St., Toronto. 1957. The papers contained in this booklet were given as a symposium by the authors and traced the development of the nursing approach to emotionally disturbed patients in this particular hospital.

* * *

Characteristics and Professional Staff of Outpatient Psychiatric Clinics by Anita K. Bahn, B.A. and Vivian B. Norman, B.S. 87 pages. Superintendent of Documents, U.S. Government Printing Office, Washington 25. 1957. Price 60 cents. "The purpose of this monograph is to provide statistical information to serve as a basis for program planning, and as a baseline for measuring trends in the number and kinds of outpatient psychiatric clinics and their professional staffs."

* * *

Study Guide and Review of Practical Nursing by Helen F. Hansen, R.N., M.A. 398 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 2nd ed. 1958. Price $4.25. The original text has been revised after study of new curricula in schools for practical nurses, recent literature pertinent to this field, and comments from readers of the first edition.

Assuming that an individual chews gum on an average of eight hours a day, we would find that in the process of chewing, her lower jaw swings against the upper jaw about once every second, or 60 chews a minute. During an eight-hour she swings the lower jaw 28,000 times against the upper jaw. In the course of a year, her gum chewing results in 10,512,000 movements of the lower jaw. Is it any wonder that her teeth are in such a deplorable state? She has literally chewed her teeth away. — Charles A. Levinson, D.M.D., in *Nursing Outlook*

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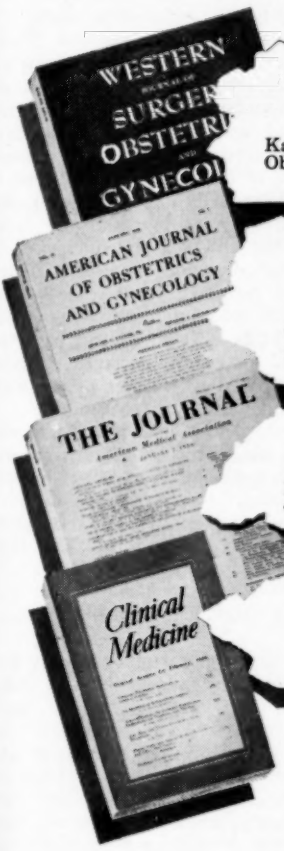

"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

"Easy and comfortable to use and eliminated odor."

Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

Three absorbencies: Junior, Regular, or Super Tampax meet varying requirements.

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An Exploratory Laparotomy

BERNADETTE GILLIS *and* LUCETTA MACDONALD

SOCIAL AND MEDICAL HISTORY

Mr. Fyfe, a prosperous 55-year-old farmer and fisherman who lives with his wife and one child in a remote corner of Canada's smallest province came to see his doctor because of the following complaints:

a. He had been losing weight for the past few months.

b. He was frequently bothered by pain in his epigastric region that occurred after meals.

c. He had a pulling sensation in his abdomen and had pain on lifting his arms.

d. His family noted that he was paler than usual.

His doctor admitted him to the hospital immediately.

PREOPERATIVE CARE

To one who has not been in a hospital before first impressions are of great importance. A friendly, understanding attitude in all personnel is necessary. From the beginning we tried to put Mr. Fyfe at ease and win his confidence. He was admitted at 4:00 P.M., introduced to his roommate who had had an abdominal operation three days before, and oriented to his surroundings. Then he was left to rest until supper time.

The doctor ordered an x-ray of his gallbladder, stomach and bowel. The preparation for this x-ray was explained to Mr. Fyfe. A fat-free supper, consisting of juice, toast, tea and jelly, was given followed by six Telepaque tablets taken at five minute intervals. Whether or not the dye reaches the blood stream depends upon

a. the condition of the gastrointestinal mucosa

b. explicit instructions to the patient

c. the cooperation of the patient in carrying out the instructions.

Mr. Fyfe was allowed nothing by mouth after midnight.

Radiological findings: The gallbladder was normal. There was some gastritis present and an overlapping of the mucous membrane along the lesser curvature of the stomach. There was no evidence of malignancy in the colon. Because of these findings a repeat x-ray was suggested by the radiologist and was carried out six days later. The irregularity along the lesser curvature of the stomach continued to show. The possibility that it was due to extrinsic pressure from the large bowel could not be ruled out.

Physical examination: Mr. Fyfe's chest was normal. Heart sounds were clear with no murmurs. His blood pressure was 120/80. There was no abdominal distention. A vaguely tender area was noted to the left of the midline, high in the epigastrium.

Laboratory findings: Urinalysis was normal; white blood cell count was 6,800, hemoglobin 12 grams — both within normal limits. Gastric analysis showed normal acidity. A serological report showed no reaction. The stool was positive for occult blood.

DIAGNOSTIC IMPRESSION

Because of the suspicious x-ray and clinical findings the doctor felt justified in doing an exploratory laparotomy on Mr. Fyfe. This was explained to him. His fear of cancer was considered natural in a man of his intelligence. The doctor told him that, since his symptoms were of short duration, even if cancer were present, the final result should still be good. Mr. Fyfe appreciated his doctor's frankness and had complete confidence in him.

PREPARATION FOR SURGERY

Mental preparation: We realized that Mr. Fyfe was fearful of the outcome of the operation and we tried to keep his mind off himself. He was

The authors are senior students in Charlottetown Hospital School of Nursing, Charlottetown, P.E.I.

Baby's Own Tablets

satisfactorily relieved

every one of 40 babies* with

constipation

and 34 out of 35 babies* with

teething

gastrointestinal upset and malaise

with complete easing of straining at stool, gas distress, disturbed sleep, restlessness, crankiness and anorexia.

REMARKABLY SAFE — "Throughout the study . . . in no instance was there any untoward reaction" whatsoever.

BABY'S OWN TABLETS provide Phenolphthalein 3/16 grain, mildly buffered with Precipitated Calcium Carbonate ½ grain, and Powdered Sugar q.s. Pleasant, convenient.

*2 months to 24 months of age.

For a sample supply and literature citing references 1-15 write . . .

Typical Case History

CASE #50. Baby R.S., age 12 months, weight 20 lb. 10 oz., had gastrointestinal discomfort and malaise associated with teething. Baby had no teeth as yet, but gums were tender, puffy and swollen. Baby was cranky, irritable, restless and couldn't sleep. Drooling was excessive; appetite poor.

BABY'S OWN TABLETS were given, one each night at bedtime.

Baby had satisfactory relief of symptoms. Appetite improved. First days, then nights, became more comfortable. Baby now has six teeth.

G. T. FULFORD CO., LIMITED, Brockville, Ontario

given a great deal of encouragement by his roommate who was making an uneventful postoperative recovery. He enjoyed going to the solarium to watch television and to chat with other ambulatory patients. The night previous to operation he was given grains four of sodium luminal to assure him a restful night.

Physical preparation: Mr. Fyfe was put on a liquid diet for 48 hours prior to surgery. Gastric lavage was done and enemata were given to insure a clean operative field. A Levine tube was put in place before he went to the operating room.

Local preparation: The usual abdominal shave was done. The skin was cleansed with ether, alcohol 65% and aqueous zephiran 1:2000 and the operative area was covered with a sterile towel. An indwelling catheter was inserted. At 8:00 A.M. morphine sulfate gr. ¼ and hyoscine gr. 1/150 were given to help relax Mr. Fyfe. He was given a spinal anesthetic. The operation started at 9:20 A.M. and ended at 12:00 noon. There was no shock; blood pressure remained stable throughout. Mr. Fyfe was given 500 cc. of whole blood.

Operative Findings

The abdomen was opened through a midline incision. It was found that the area of the stomach along the greater curvature was adherent to the anterior abdominal wall by means of an adhesion one and one-half inches thick. This would explain the pulling sensation and the pain on lifting his arms that Mr. Fyfe had experienced. There was also a small mass in the transverse colon just opposite the lesion in the stomach and in between were small swollen glands. This latter mass had not shown in the x-ray. Because of the affected glands a colonic resection and a subtotal gastrectomy were done. The whole mass was removed in one piece.

Pathology report: a. Benign gastric ulcer. b. Carcinoma of the large bowel with extension.

Postoperative Nursing Care

The treatment and the nursing care

TALKING

TALKING

Tired of TALKING Reducing Diets?

Save time . . . reduce tedious repetition. Suggest the Knox "Eat and Reduce" Booklets for cardiac, hypertensive and obese patients. Color-coded diets of 1200, 1600 and 1800 calories are based on Food Exchanges[1]. . . . eliminate calorie counting . . . promote accurate adjustment of caloric levels to the individual patient.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

of a patient following surgery have been greatly simplified during the past few years. One of the modern advantages is the recovery room. This room is equipped with oxygen, suction, emergency drugs and other facilities. It is located within the operating suite and is supervised by a well qualified graduate nurse and a doctor.

Mr. Fyfe was taken to the recovery room at 12:05 P.M. His condition was good — pulse rate 120 per minute, respirations 20, B.P. 110/80. His blood transfusion was still running. When finished it was followed by 1000 cc. of 5% glucose in normal saline. The Levine tube was connected to the electric Gomco, for suction siphonage at low pressure, to remove the mucus, liquids and gas that accumulate in the stomach. This gives the suture line a chance to seal off thoroughly and minimizes the danger of leakage into the peritoneal cavity. The Levine tube was irrigated with normal saline p.r.n. to keep it clean. Antibiotic therapy was started and continued for 72 hours.

Mr. Fyfe was transferred from the recovery room to his own room at 3:00 P.M. During the first 24 hours he was given nothing by mouth except ice chips. His fluid and electrolyte balance were maintained by intravenous fluids — 3000 cc. over each 24-hour period.

Oral hygiene: Mr. Fyfe's mouth was very dry due to the continuous suction. He was given antiseptic mouth wash t.i.d., followed by swabbing with lemon and glycerine to stimulate the salivary glands. The salivary glands, if allowed to remain inactive, may become infected by the bacteria that accumulate in a dry mouth. This causes parotitis (surgical mumps). Parotitis is a dangerous and very painful postoperative complication. Mr. Fyfe liked to suck hard candy and this helped to keep his mouth moist.

Diet: After 48 hours a mixture of milk and water in equal parts, one ounce every hour, was given. The amount was increased gradually until three to four ounces were being taken. Custard, jello, cream of wheat were added to the diet on the third and fourth days. Mr. Fyfe was given small

Each brochure is packed with 14 pages of kitchen-tested recipes plus color-coded, gate-fold "Choice of Foods" Chart

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Your name and address

feedings often and tolerated them well. On the seventh day he was put on convalescent ulcer diet. The Levine tube was clamped off for 12 hours to make sure that the stomach was emptying before finally removing the tube. Sometimes edema around the anastomosis causes retention of stomach contents and vomiting will occur when the tube is removed.

Early ambulation: Mr. Fyfe was out of bed on the day following surgery. Each day, activity was allowed within the limits of his tolerance. Early ambulation helps to prevent vascular complications by improving the general circulation. Atelectasis and hypostatic pneumonia are relatively rare when the patient is ambulatory. Postoperative distention and the annoying "gas pains" are almost absent because the tone of the gastrointestinal tract and the abdominal wall is maintained.

Rehabilitation and health teaching: Mr. Fyfe considered himself very fortunate when the doctor explained the operative findings to him. The malignant tumor in the bowel did not show up in x-ray because it was so early and had not as yet caused any irregularity in the bowel outline.

Since his home conditions were good, and his wife was quite capable of giving him adequate care, Mr. Fyfe was allowed to go home 16 days after his operation. He was instructed to follow a bland diet for at least six weeks and to report back at the end of that time. His nurses kept in contact with him through his doctor. According to latest reports he has gained 20 pounds and is back at work. He has no complaints whatsoever.

We have learned from nursing Mr. Fyfe that a patient who is well prepared for an operation and has confidence in his doctor, his nurses and the hospital staff has a smoother convalescent period. The nervous, apprehensive patient tends to get into trouble. He may have less tolerance to pain, and will demand narcotics more frequently. He may have a greater tendency to develop nausea and vomiting, inability to void, or postoperative distention. Good nursing care

LECTURING

LECTURING

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helps the patient to be calm and to acquire confidence. Consideration of the patient's mental attitude will benefit him in every way.

Random Comments

Permettez-moi de vous féliciter sur la simplicité et la précision du nouvel emblème de l'Association des Infirmières canadiennes. En le comparant avec l'autre aussi chargé qu'une boutique d'antiquaire, on se demande pourquoi on n'y a pas songé plus tôt!

Y. R. T., Quebec.

* * *

I do enjoy your magazine tremendously, find the articles stimulating and interesting and much of the material is directly useful to me in my work. I am a vocational guidance officer with the Department of Education.

M. W., New Zealand.

* * *

During the past months the regular receipt of *The Canadian Nurse* has been very important to me. I certainly enjoy the great variety of didactic articles published therein and I'm looking forward to them each time. Thank you for all the work and effort put into making the magazine such a success.

H. K., Alberta.

* * *

In renewing my subscription I would like to add a few words of appreciation for your magazine. My Australian colleagues and I look forward to its coming and compliment you on the standard you maintain. Climates and conditions vary, but we find sick people present the same nursing problems the world over.

D. J., Australia.

* * *

Would like to take this opportunity to express my appreciation of the articles found in *The Canadian Nurse*. The drug summaries are especially good.

R. R., Ontario.

For the first time, a diet brochure offers detailed daily suggested menus for all types of convalescent diets, plus 14 pages of tested nourishing recipes.

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I enjoyed your July issue very much. The students who did the case studies have spent much time and effort on them. It reminds me of my student days which were not so long ago. D. B., Ontario.

* * *

I have meant to write and tell you how much I enjoy reading the various nursing articles written by the student nurses. Being a full-time worker as well as keeping house with a family of one child, I seldom find time to read books on nursing. But no matter what else has to be skipped, I read *The Canadian Nurse* and feel that I do keep up with the modern trends in bedside nursing. R. G., Alberta.

Book Reviews

Essentials of Nutrition by Henry C. Sherman, Ph.D., Sc.D. and Caroline Sherman Langford, Ph.D. 475 pages. Brett-Macmillan Limited, 132 Water St. S., Galt, Ont. 4th ed. 1957. Price $4.90.
Reviewed by Mrs. G. Savard, Dietitian-in-Charge, St. John's General Hospital, St. John's.

This is an introductory study of the basic elements of nutrition. Readers require no previous training in science. The information can be used equally well by someone who intends to proceed to further study, or by one who is primarily interested in securing the "true" story of this popular subject.

The objective of nutrition is maximum health and efficiency for everyone through an adequate knowledge of food, and the application of this knowledge to living. The authors have succeeded in presenting a concise account of the modern concepts of this science in simple, everyday language that should help to secure this application.

Food maintains life. Selection of proper foods determines the degree of health and efficiency. The component elements of food are studied in the light of the most recent findings. The necessity for a balanced diet containing specified amounts of these elements is explained. The recommended daily allowances are included, and a reference to minimum allowances is made. The application and extension of nutrition study is discussed briefly, but very interestingly. Additional features are: lists of useful data on nutrient values of foods; glossary of nutritional terms; and a thoroughly adequate list of reference readings that will prove to be an invaluable asset for those interested in more detailed specific information.

Manual of Recovery Room Care. Edited by John M. Beal, M.D. Brett-Macmillan Ltd., 132 Water St. S., Galt, Ont. 1956. Price $3.75.
Reviewed by Miss Mary Warnock, Operating Room Supervisor, Royal Victoria Hospital, Montreal.

One of the most significant advances in the care of the surgical patient is the post-anesthetic or recovery room unit. To those who are responsible for the service and the training of personnel for the unit, this is a valuable teaching and reference manual.

As the skills and knowledge required for good postoperative care have increased, the necessity for an alert, well-trained and responsible staff has become a recognized fact. The manual illustrates clearly how to organize, administer and maintain such a service. In order to ensure the maximum in good patient care, it stresses the need for teamwork between the surgeon, the anesthetist and the nurse.

In the initial observation period following surgery, the appearance and reaction of the patient is of the utmost importance. In a concise and simple manner the complications and problems that may arise following the different types of surgery are explained and detailed treatment is offered. The reader is given a clear understanding of how many serious complications can and must be prevented.

The last chapter of the manual deals with cardiac arrest, showing how to recognize, treat and prevent such a major complication. This detailed, easily read, informative manual is a valuable addition to the library of a recovery room unit.

Practical Nutrition by Alice B. Peyton, B.S., M.S. 364 pages. J. B. Lippincott Company, 4865 Western Avenue, Montreal 6. 1957. Price $3.60.
Reviewed by Miss J. McClure, Dietitian in Charge, General Hospital, Brandon.

It is pleasant to find a book on nutrition that bears in mind that the student nurse is not a student dietitian. The material presented adequately covers the subject and makes for easy reading and study.

The chapters on "Special Diets" are concisely and clearly presented for the student nurse. The average homemaker would be greatly benefited in her family problems by the chapters on "Meal Planning for the Family."

The section on marketing and food values could be of much use in teaching future homemakers. This section could also be very helpful to New Canadian housewives who find difficulty in shopping where food habits, customs, and even nomenclature differ so radically from their accustomed pattern.

This book would be a valued asset to the library of any homemaker, dietitian, teacher or student.

Headache — Diagnosis and Treatment by Robert E. Ryan, B.S., M.D., M.S., F.A.C.S. 407 pages. The C. V. Mosby Company, St. Louis. 2nd Ed. 1957. Price $6.75.

Reviewed by Dr. A. A. Bailey, Dept. of Neurology, University of Saskatchewan, Saskatoon.

This is a book that deals with a common ailment of human beings. The author attempts to cover the entire subject of headache in this small volume and actually refers to most of the items which, at one time or another, have to do with the problem of headache. Most of the items are dealt with in a rather superficial fashion. There is a lack of critical evaluation of suggested treatments. It is doubtful that the author has had an extensive experience in all the fields that he attempts to discuss.

There is much repetition. Many subjects have not been dealt with in sufficient detail to enable one to either make a diagnosis or carry out satisfactory treatment of the disorder under discussion. I do not believe that the book is useful to physicians in any type of practice and I would not recommend it to general practitioners or to nurses. The subjects about which the author is most qualified to speak, namely those having to do with ear, nose and throat, are not satisfactorily covered.

Moral Handbook of Nursing by Rev. Edward J. Hayes, Rev. Paul J. Hayes, and Dorothy Ellen Kelly, R.N. 155 pages. Brett-Macmillan Limited, 132 Water St. South, Galt. 1956. Price $2.50.

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Reviewed by Sister Mary David, Director of Nurses, Charlottetown Hospital, Charlottetown.

This text contains a wealth of information on nursing ethics written very concisely and in simple language. It is a practical handbook since it is well-indexed and has paragraphs numbered for ready reference. The illustrations and charts add to the clarity and usefulness of the book.

The authors deal first with the basic principles of nursing ethics. Very complete definitions of ethics, the natural law, and conscience are found here. The principle of the two-fold effect is well explained.

The responsibilities of the nurse to her patient are clearly set down. This chapter includes a discussion of the virtue of justice, professional secrecy and the spiritual care of the patient.

Part II — "The Nurse's Spiritual Life" — is written for the nurse herself. She is reminded that the reason she became a nurse was that she was convinced that nursing is the field where she can best fulfill the will of Christ. When she looks upon her profession as a vocation, she will live in an atmosphere that gives meaning to the problem of pain.

This convenient-sized, well-written, and informative little book is one which this reviewer can recommend highly to all those interested in the subject of nursing ethics.

Religious Doctrine and Medical Practice by Richard Thomas Barton, M.D. 94 pages. The Ryerson Press, Toronto. Price $4.00.

Canada, as one of the relatively "new" countries of the world, has welcomed a broad variety of racial groups as citizens. This has brought with it a very diversified range of religious sects and denominations, many of whom have specific teachings respecting health practices, dietary habits, care in illness and at the time of death. In addition, there are several religions of American origin that now claim many adherents among Canadians.

Among this bewildering mixture of beliefs and customs, Dr. Barton has produced a handbook that will be extremely useful as a source of information to nurses and dietitians as well as to the physicians and surgeons for whom it was written. Briefly, he has outlined the history of the development of many of the religions, their beliefs regarding the nature of disease, the dietary restrictions that are observed, the role of the physician in providing therapy, and the teachings regarding psychiatric care.

Even so simple a practice as offering a cup of tea may be an offense to an adherent of a faith that deplores "hot drinks." Can this patient have meat or must he be on a strictly vegetarian diet? Which faith is it that requires that the clergy bless the patient before surgery is undertaken? Will the patient submit to blood transfusion?

These and countless other questions that may crop up in any situation where a nurse may be employed are given authentic answers. Dr. Barton gives the sources of his information and provides supplementary reading lists for those who may wish to delve further.

This monograph is a most useful handbook that deserves a place in a school of nursing reference library.

Communicable Diseases — a Textbook for Nurses by Albert G. Bower, A.B., M.S., M.D., F.A.C.P., the late Edith B. Pilant, R.N., and Nina B. Craft, R.N., B.S., M.S. 704 pages. W. B. Saunders Company, West Washington Square, Philadelphia 5. 8th Ed. 1958. Price $7.50.

Vigorous immunization campaigns have virtually eliminated a few of the more common communicable diseases in the past half century. The mortality rate from many others has been reduced very appreciably. Some isolation hospitals have been closed or converted to receive other types of illness. The net result of this widespread evidence of the value of prevention has been to convince a considerable portion of the public that great conquests of disease have been made.

It is true that enormous strides have been taken. Yet, a glance through the table of contents of this latest edition of a well known text will indicate clearly that there is a wide range of communicable diseases that still beset human beings. Over fifty chapters describe the etiology and treatment of the many well known as well as the less commonly seen diseases that are spread by organisms.

The present day concept of medical aseptic technique is reviewed. Special chapters are devoted to the care of communicable diseases at home and the control programs that are in effect under the health departments. The diseases are listed under their common rather than their scientific names for greater ease in locating desired information. Since many nurses seldom see some of these communicable diseases the personal possession of an authoritative text such as this would be very advantageous.

British Columbia

The following is a list of the staff changes in the Metropolitan Health Services.

Appointments — *Elsa Alsgard* (Galt S. of N., Lethbridge, U.B.C.). *Jessie Brezden* (U.B.C.). *Marion Cochran* (Royal Jubilee Hosp., Victoria, U.B.C.). *Barbara Deane-Freeman* (U.B.C.). *Jean Francis* (U.B.C.). Mrs. *Phyllis Galloway* (Vancouver Gen. Hosp., U.B.C.). *Deirdre Giles* (U.B.C.).

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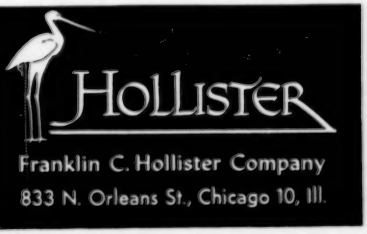

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Margaret Goldsmith (Holy Cross Hosp., Calgary, U.B.C.). *Shirley Heslop* (St. Paul's Hosp., Vancouver, U.B.C.). *Phyllis (Parker) Irvine* (Vancouver Gen. Hosp., U.B.C.). *Juliette (Grimson) Jabour* (U.B.C.). Mrs. *Phyllis Killeen* (U.B.C.). *Marie Kluck* (U.B.C.). *Rita Larsen* (U.B.C.). *Carol (Valens) McGregor* (U.B.C.). *Joan Morison* (V.G.H., U.B.C., M.A., Columbia Univ.) *Frances Murphy* (St. Paul's Hosp., Vancouver, U.B.C.). *Frances New* (V.G.H., U.B.C.). *Carol Partridge* (U.B.C.). *Thelma Sieffert* (V.G.H., U.B.C.). *Dorothy Upper* (Metropolitan S. of N., Windsor, U.B.C.). *Heather (Clark) Wiginton* (U.B.C.). Mrs. *Barbara Winslow* (Univ. of West. Ont.).

Resignations — *Lorna (Calderwood) Baker*, Mrs. *Frances Barnes, Eva (Anderson) Brummer, Gertrude (Le Page) Buckley*, Mrs. *Pearl Glen*, Mrs. *Bernice Hatcher*, Mrs. *Henrietta Holmes, Thelma Johnson, Oonagh (Donald) McClure, Ruth (Burgman) Pestell, Elizabeth Scoffield, Frances (Thompson) Vesterdahl, Grace (Pettifor) Williams, Elizabeth (Donald) Wynne, Marilyn (Gowan) Young.*

Mabel Parrett who recently completed a course in public health administration at

the University of Toronto, has been appointed assistant supervisor in a health unit.

Margaret Briggs has been granted a leave of absence to attend the University of Toronto where she will be enrolled in the public health administration course.

News Notes

BRITISH COLUMBIA

VICTORIA

Royal Jubilee Hospital

The following members of the alumnae association form the executive for the coming year: Mrs. M. McCague, pres.; Mmes B. Owen, E. Bolt, vice-pres.; Mrs. R. Birtwhistle, sec.; Mrs. S. Mourant, asst. sec.; Mrs. V. McConnell, treas. A bazaar is to be held this month as a fund-raising project of the association. Part of the money from last year's bazaar was used to purchase a new organ for Pemberton Memorial Chapel. The Sick Nurses' Fund, bursary for postgraduate study, the fund to aid student nurses and the capping ceremony are activities sponsored through the same source of funds.

MANITOBA

BRANDON

General Hospital

The class of '33 celebrated their 25th anniversary in August. Dinner was served at the Suburban restaurant and a social evening followed at the home of Mrs. C. Cripps. Those attending the reunion were : F. (Detwiller) Strome, L. (McCoy) Mathewson, G. (Kennettle) Watts, D. (Dick) Jarvis, G. (Slimmon) Smith, D. (Mooney) Curran, G. (Mumford) Muir, A. (McMillan) Poitras, M. (McKinnon) Steart, F. (Hudson) McArter, E. (Hansen) Conner, A. (Fallas) Ingle, W. (Badger) Cripps.

The members of the graduating class of '58 have many pleasant memories of the activities leading up to graduation exercises. A dinner at the Prince Edward Hotel at which they were guests of the alumnae association was one highlight. Graduates and their parents were entertained at a tea in the nurses' residence and several other teas were held in private homes. Graduation exercises were held in St. Paul's United Church with Mr. G. L. Pickering, Commissioner of Hospital Insurance for Manitoba, as the guest speaker. Janice MacDonald was the recipient of the gold medal presented by the medical staff while Beverley McRae and Gwendolyn Lythgoe received the silver and bronze medals respectively.

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Director of Nursing Education for 500-bed general hospital with a school of nursing. Applicant must have a degree in nursing. Salary commensurate with experience & qualifications. Apply to, Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Assistant Director of Nurses, Clinical Instructor and Staff Nurses. Rehabilitation nursing in crippled children's center. Top salaries. For further information, write Crotched Mountain Rehabilitation Center, Greenfield, New Hampshire, U.S.A.

Supervisors for afternoon and night shifts for 142-bed general hospital. Experience required. University certificate desirable but not essential. 5 dy., 40-hr. wk. Liberal benefits. Opportunity for advancement. Apply in writing stating salary expected to, Matron, North Vancouver General Hospital, North Vancouver, B.C.

Night Supervisor for 74-bed hospital with planned extension. Gross salary schedule $250 — $280 depending on experience & qualifications. Favorable personnel policies & pleasant working conditions in the heart of the Lake of the Woods sports area. Apply Superintendent, General Hospital, Kenora, Ontario.

Assistant Night Supervisor — Head Nurses for Medical & Surgical Wards — **General Duty Nurses** for 450-bed hospital with training school. Excellent personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

Administrative Supervisor — Pediatric Dept. 30-bed unit in modern hospital; good personnel policies. Apply: Director of Nursing, Civic Hospital, Peterborough, Ontario.

Nursing Supervisor for small hospital in Northwest Territories. Good wages & living conditions. Apply stating training & experience to Superintendent, Yellowknife District Hospital, Yellowknife, N.W.T.

Operating Room Supervisor required immediately. Postgraduate training essential. Contributory pension scheme available after two years employment. Apply, Supt., Grace Hospital, St. John's, Newfoundland.

Operating Room Supervisor for 60-bed hospital with expansion program to 80 beds; 51 miles from Ottawa, 65 miles from Kingston. Experience desired. Apply, Superintendent, Great War Memorial Hospital, Perth, Ontario.

Operating Room Supervisor, Night Supervisor, Assistant Head Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

Wanted: Qualified experienced Hospital Administrator, state qualifications & salary expected. Apply to: Mrs. L. W. Borthwick, Sec.-Treas., Morden District General Hospital, Morden, Manitoba.

Nurse Superintendent for 50-bed hospital. Preference given to nurse having postgraduate training in hospital administration. Please state past experience, age, salary expected, etc. Personal interview invited. Apply to: Stanley Acheson, Chairman, Centre Grey General Hospital, Markdale, Ontario.

Assistant Matron with postgraduate preparation for 140-bed hospital with building program in operation. For further particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Clinical Instructor-Medical-Surgical Nursing — 40 students 1 class a yr. 40-hr. wk. For further information please apply Director of Nursing, Yorkton General Hospital, Yorkton, Saskatchewan.

Registered Nurse (1) Licensed Practical Nurse (1) for 10-bed rural hospital. Highest salaries paid. For full particulars write, Secretary-Treasurer, Box 235, Fisher Branch, Manitoba.

Registered Nurses (2) for 16-bed modern hospital salary $260 per mo. gross, $5 increments each 6-mo. for 4 increases, 8-hr. day, 44-hr. wk. 3 wk. vacation with pay after 1-yr. service plus statutory holidays, living quarters in hospital. Apply: Secretary or Matron, Wilson Memorial Hospital, Melita, Manitoba.

Registered Nurse (1) for modern 30-bed hospital. Starting salary, $260. gross per mo. 44-hr. wk. Overtime pay 4-wk. vacation after 1 full yr. All statutory holidays. Accumulative sick time. Excellent personnel policies and working conditions. Apply, Secretary-Treasurer, Roblin District Hospital, Roblin, Manitoba.

Registered Nurses: for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses for general duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for medical, surgical, obstetrical, pediatric & geriatric departments. Gross salary: $235, with annual increments. 5-day wk., 8-hr. day. 21-day vacation 1st & 2nd yr. 28-day, 3rd yr. Sick leave accumulative to 60 days. Transportation up to $50 paid after 1 yr. service. Community hospital in lake area. Apply: Director of Nursing, General Hospital, Port Arthur, Ontario.

Registered Nurses for new, modern 640-bed county hospital. Salary: $338-$392 per mo. Excellent working conditions. Liberal sick leave, vacation, retirement benefits. California registration or eligibility for registration required. Apply, Administrator, Kern General Hospital, Bakersfield, California.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, Calif.

Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days; paid vacation; 7 paid holidays; sick leave. Surgery starting base pay $338 stand by & call back time extra. **Staff R.N.** starting pay $322 monthly; regular pay increases; P.M. & night differential $10. Apply: Yolo General Hospital, P.O. Box 210, Woodland, California.

Registered Nurses & Licensed Practical Nurses (Male & Female) staff positions available on general staff & special departments for 250-bed nonsectarian hospital located on beautiful Allison Island, Miami Beach, Florida. Accommodations for living-in available. Apply: Director of Nursing Service, St. Francis Hospital, Inc., Miami Beach 41, Florida.

Registered Nurses-Head Nurses for new & modern hospital offering an opportunity for nursing participation in a dynamic physical & medical rehabilitation program. **Salary Range: Registered Nurses** — $3,580 — $4,610; **Head Nurses** — $3,832 — $4,850. Maximum reached in five (5) years. 40-hr. wk., sick & vacation leaves plus 12 legal holidays, State civil service; retirement plan & social security, free laundry service for uniforms. Rooms available at $12-$16 monthly. If registered in home Province, can in most instances obtain Maryland license through reciprocity. Apply: Superintendent, Montebello Hospital, Baltimore 18, Maryland.

Registered Nurses— Salary $325-$360 in 18 mo. differential on p.m. shift $1.50, nights $1. Openings in Obstetrical & Medical-Surgical areas. Apply to Personnel Dept. Woman's Hospital, 432 E. Hancock Ave., Detroit 1, Michigan.

Registered Nurses for 88-bed voluntary non-profit hospital in Community of 11,000. Basic salary $295 per mo. with increments of $5 every 6-mo. up to 2-yr.; 40-hr. wk.; 7 paid holidays; sick leave accumulative to 36-dy. Address inquiries to: Director of Nurses, St. John's Hospital, Red Wing, Minnesota.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Registered Nurses & Certified Nursing Assistants for new expanding 88-bed hospital in a pleasant progressive town. **General Duty Registered Nurses** start $220, annual increments to $240, **Certified Nursing Assistants** $150, annual increments to $180. 2-wk. shift rotation, bonus for 4-12 & 12-8 shifts. Accumulated sick leave to 60-dy. Only 1-hr. drive to Toronto, to other cities & resort areas. Local swimming pool, artificial ice arena, bowling, etc. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses and trained Nursing Aides needed for a large expanding City Hospital in Edmonton, Alberta. **General Duty** $240 - $270 per mo. plus laundry; **Staff Nurses** $270 - $300 per mo. plus laundry; **Certified Nursing Aides** $168 - $189 per mo. plus laundry. Experience available in all departments including Operating Rooms & Case Rooms. Credit given for postgraduate work & past experience. Opportunities for advancement. Liberal sick leave & vacation allowances. 40-hr. wk. For particulars apply to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for modern 60-bed general hospital 40-mi. south of Montreal. Salary $250 per mo. $5. increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts, 44-hr. wk. Board & accommodation available in new motel-style nurses' residence. Apply: Supt. Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Duty immediately, in 19-bed hospital located 95-mi. south-west of Edmonton. Close to three (3) summer resorts this oil town offers many varied entertainments. There is daily bus & train service to other points in the province. Starting wages are $220 per mo. plus maintenance with a $5 increase every 6-mo. For further information please write or phone. The Matron, Rimbey Municipal Hospital, Rimbey, Alta.

Registered Nurses or Graduate Nurses for General Duty (2) for 16-bed hospital. Salary schedule according to the A.A.R.N. suggested policy. Basic starting for R.N. without experience $240 & if experienced, salary adjusted accordingll, otherwise increment increases every 6-mo. up to 3-yr. Maintenance $30. Blue Cross group, annual leave of 1-mo. etc. Hospital is centrally located between two (2) Lake resorts. Mrs. J. Bergquist R.N. Matron, Bentley Municipal Hospital #43, Bentley, Alta.

Registered or Graduate Nurses for 110-bed municipal hospital situated in the Peace River district of Northern Alberta. Salary $250 gross. $5 per mo. increase each 6-mo. up to 4 increases. 8-hr. shifts-44-hr. wk. 3-wk. vacation with pay after 1-yr. service. Statutory holidays. Accommodation in nurses residence, $30 per mo. Also **Evening & Night Supervisors** wanted. Salary open. Apply to, Sec.-Treas. M. G. Stanton, Grande Prairie Municipal Hospital District #14, Grande Prairie, Alta.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $240 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered General Duty Nurse for 20-bed hospital, 36-mi. north of Winnipeg, Manitoba. Starting salary $225 with full maintenance. Please apply stating age & qualifications. To Superintendent, Hunter Memorial Hospital, Teulon, Manitoba.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses & Certified Nursing Assistants for new 58-bed hospital. Situated in North Western Ontario. Gross Salary $249 per mo. & $184 per mo., subject to increase after 6-mos. with regular annual increases thereafter. $45 per mo. room & board. Rail are refunded after one year. New 21-bed nurses' residence, single rooms. Apply; stating age & when available to Director of Nursing, District General Hospital, Dryden, Ont.

Registered Nurses for General Duty. Salary range $235-$265 depending on qualifications. Residence accommodation available. 74-bed general hospital on beautiful Lake of the Woods. Forward enquiries to Superintendent, Kenora General Hospital, Kenora, Ontario.

Registered General Duty Nurses (2) for well equipped 40-bed hospital. Starting salary $200 plus full maintenance. 8-hr. duty, 44-hr. wk. with 40-hr. contemplated. Rotating shifts, long week-end following night duty. Apply: Superintendent Saugeen Memorial Hospital, Southampton, Ontario.

Registered General Duty Nurses for County Hospital 45 mi. from center of Montreal with excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, bowling, curling & dancing. 8-mi. from summer resort on Lake St. Francis & 12-mi. from U.S. border. Gross salary: $215 per mo. Three $5.00 increases at 6-mo. intervals to maximum $230. 44-hr. wk. 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 1-mo. annual vacation, all statutory holidays. 2-wk. sick leave. Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Quebec.

Registered General Duty Nurses required for 265-bed tuberculosis sanatorium. Starting salary, $250, maximum $285. Time and a half for all statutory holidays worked. 40-hr., 5-dy. wk. No night or evening duty. Good personnel policies. Maintenance, $37.50 per mo. Apply, Supt. of Nurses, Prince Albert Sanatorium, Prince Albert, Sask.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $340 for days, $370 for evenings, $360 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered General Staff Nurses (6) starting salary $255-$325. **Trained Nurses' Assistants** (4) starting salary $165-$200 for an accredited 75-bed hospital 40-hr. wk., yearly increment — full maintenance $35 — Personnel practices in accordance with S.R.N.A. policies. Apply: Superintendent, St. Therese Hospital, Tisdale, Saskatchewan.

Registered Laboratory Technician, to take charge of laboratory in a modern 88-bed general hospital. Very pleasant & progressive town, near large cities & resorts. Apply: stating salary expected, to the Administrator, Dufferin Area Hospital, Orangeville, Ontario.

General Duty Nurses (2) for modern 35-bed hospital. Salary $220 per mo. plus full maintenance, 3-$10 per mo. annual increments. 1-mo. holiday pay, 2-wk. sick leave. If employed for 1-yr. a refund of train fare from any point in Canada will be given. Apply to: Two Hills Municipal Hospital, Two Hills, Alberta. Phone 335.

General Duty Nurse (1) for rotating shift (30-bed hospital). Salary: $260 per mo. less $40 for room, board & laundry. 40-hr. work wk. 4-wk. vacation with pay after 1 yr. service. 1½ days sick leave per mo. yearly accumulative. Attractive nurses' home adjoining hospital. Apply: Community Hospital, Grand Forks, British Columbia.

General Duty Nurses for a new hospital in the Fraser Canyon, 100-mi. from Vancouver. Salary $260 — Shift differential, 40-hr. wk.; 10 statutory holidays; 1-mo. annual vacation. Accommodation available in a new nurses' residence. Apply: Director of Nurses, Fraser Canyon Hospital, Hope, British Columbia.

General Duty Graduate Nurses (2). Salary $260 per mo. with annual increments of $10 per mo. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $250-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for modern 25-bed hospital. Good personnel policies, excellent living quarters. Apply: Supt. of Nurses, Mrs. A. Robertson, Plaster Rock, New Brunswick.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7-mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $235 per mo. with annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $240 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Registered Nurses for 100-bed general hospital in town of 6000 on the shore of Lake Huron. Good personnel policies, residence accommodation available. Apply: Superintendent, Alexandra Marine & General Hospital, Goderich, Ontario.

General Duty Nurses. O.R. Scrub Nurse (1). For modern well equipped 100-bed general hospital in friendly community. Gross salary: $240 per month if currently registered in Ontario. 8 hr. rotating shifts. 44 hr. wk. 1 day off 1 wk. and 2 the next. 21 days vacation after 1 yr. 7 legal holidays. Good personnel policies. Apply, Miss Willamene R. Allan, General Hospital, Port Colborne, Ontario.

General Duty Nurses for modern 42-bed hospital, starting salary, new graduates $245 with two (2) yr. experience $255; these rates to be revised October 1st. Ontario registration required for maximum salary. Annual increments, 6% bonus for evening & night shifts. 44-hr. wk. with 8 statutory holidays, annual vacation 21 days first yr. 28-dy. thereafter, monthly sick time allowance. Good living accommodations available. Apply to: Nursing Supervisor, Sioux Lookout General Hospital, Sioux Lookout, Ontario.

General Duty Nurses for 163-bed Tuberculosis Sanatorium. Good salary & personnel policies. Residence accommodation available. Please apply Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses for 100-bed modern hospital in south western Ontario. Please apply to: Director of Nurses, Tillsonburg District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for 600-bed teaching hospital in central California. Inservice educational program. Salary $337 — $396; 40-hr. wk. 11 holidays yearly, retirement & sick leave plan. Differential of $20 per mo. PM shift; $15 night shift; Write Personnel Director, 732 East Main St. Stockton, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary: $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in psychiatry & pediatrics on a segregated service. Apply Superintendent, Community Hospital, Alamosa, Colorado.

General Duty Nurses for 120-bed modern general hospital. Salary open. Located on the beautiful Niagara Frontier. Centrally located in Buffalo, New York, 15-min. from Niagara Falls, 1½-hr. from Toronto. Apply: Buffalo Columbus Hospital, 300 Niagara Street, Buffalo 1, New York.

Graduate Nurses for 70-bed General Hospital. Salary $260-$280; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 yr. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurse General Duty to commence as soon as possible; salary $250 per mo. Less $48 for full maintenance in new modern nurses residence. 40-hr. work wk., 28 days holiday after 1-yr. service; 10 statutory holidays & fare refunded up to $40 after 1-yr. service. Apply: Miss F. Gerwing, Nursing Supervisor, Golden General Hospital, Golden, B.C. — Full Information Available.

Graduate Nurses for new 140-bed hospital. 1. Charge nurse for Central Supply, to open and organize dept. 2. Head nurse for Pediatric dept. 3. Head nurse for men's Medical and Surgical 24-bed dept. 4. Operating Room nurse (1) 5. General duty nurses. Positions 1 to 4 all to have postgraduate courses or equivalent in experience. Salaries and personnel policies in accordance with R.N.A.B.C. Positions open August to November 1. Apply, Director of Nursing, General Hospital, Chilliwack, B.C.

Graduate Nurses; For new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses (2) for permanent general duty in modern, 26-bed hospital. Starting salary, $260 per mo. Annual increments, $10 per mo. for 3 yr. 4-wk. vacation with pay after 1-yr. service. Complete living accommodation in nurses' residence. Duties to start as soon as possible. For further particulars, apply, Hilda M. E. Smith, Matron, Minnedosa District Hospital, Minnedosa, Manitoba.

Recent Canadian Graduate with B.Sc.N. required. Starting salary, $392. Further information on request. Apply, Director of Nursing Service, Tulare-Kings Counties Hospital, Springville, California.

Graduate Staff & Operating Room Nurses 225-bed general hospital, near New York City. Salary $290, including benefits; $30 bonus for evening, $25 for night, extra for call duty. Apply: Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

General Staff Nurses (Immediately) for new 288-bed modern hospital opened in January. School of Nursing with a present enrollment of 53 students. Comfortable nurses' residence. 40-hr. wk. Liberal personnel policies. Please apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Staff Nurses for 250-bed General Hospital, located on the Bay of Quinte; approved School of Nursing; planned In-Service education program; desirable personnel policies. For further information, Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity. Liberal personnel policies. Salary $320-$360. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 170-bed hospital; starting salaries $315-$345 per mo. 40-hr. 5-dy. wk. Positions available in Psychiatry, Operating Room & on Medical-Surgical floors. Call & stand-by time is paid O.R. personnel in addition to salary. Paid hospitalization, life insurance, vacation & many other benefits. Write for brochure to Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Pediatric Nurses for 100-bed Pediatric teaching hospital; air conditioned. Good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Operating Room Nurse with postgraduate or experience for 106-bed hospital. New hospital & Nurses' home under construction. For further information apply: Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Operating Room Nurses for 370-bed approved General Hospital with an intern-resident program. 7 theatres; 650 to 750 cases monthly. Starting salary $330 or $340 per mo. according to experience. $20 per mo. merit increases at 12, 24 & 36 mos. 40-hr. wk. 2-wk paid vacation. Paid sick leave, 7 paid holidays. Resort location in California's finest recreational area. Apply to: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Ave., Long Beach 13, California.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential surburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40 hr. wk. Salary: $365 for days, $395 for evenings. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Operating Room & Staff Nurses for 230-bed Tuberculosis Hospital, located in the beautiful Willamette Valley. Starting salary $320; following 6-mo. satisfactory trial service $336; 40-hr. wk. 9 paid holidays a yr. Social Security & retirement benefits, full maintenance $40 a mo. Apply Superintendent of Nurses, Oregon State Tuberculosis Hospital, Route 4, Box 28, Salem, Oregon.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurse (Qualified). For generalized program in city of 53,000. Starting salaries dependent on experience: minimum, $3250, maximum, $4000. Annual increment, $200. 4-wk. annual vacation. Pension plan, Blue Cross, P.S.I. employer shared. Transportation provided. Apply, Dr. C. C. Stewart, B.A., M.D., D.P.H., Medical Officer of Health, City of Oshawa, Ontario.

Public Health Nurse, qualified, for general program 20-mi. from Toronto. Salary range $3,250 — $4,000. Allowance for experience. 4-wk. vacation; cumulative sick leave; Blue Cross Group Insurance; Pension Plan. Apply: The Director, Ontario County Health Unit (Southern Area), Pickering, Ontario.

Public Health Nurses for generalized program, rural & urban. Salary range $3,300-$4,300. Annual increment $200. Pension plan, Blue Cross, 4-wk. vacation, cumulative sick leave. Apply: J. R. Mayers, M.D., D.P.H., Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Certified Nursing Assistants for immediate vacancies in an accredited 64-bed hospital. Starting salary $180 per mo. annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses (3) for 14-bed hospital located in southeastern Alaska. Starting salary $300 per mo. For further information write via airmail to Superintendent, Bishop Rowe Hospital, Wrangell, Alaska.

Registered Nurses for General Duty 76-bed hospital. Salary $260 & $15 3-11, $20 11-7 per mo. $5 per mo. increase after 6-mo. service; 40-hr. wk. 2-wk. vacation & holidays with pay after 1-yr. Nice college town. Apply: Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota.

Registered Nurses for 31-bed hospital. 40-hr. wk. salary $262, increments $5 semiannually. Single room accommodation in nurses home, $10 per mo. Full board $30 or single meals 50¢ each. Steamship fare from Vancouver refunded after 6-mo. For further information & copy of personnel policies, write to the Administrator, General Hospital, Box 640, Ocean Falls, British Columbia.

Public Health Nurse training & experience with children, to supervise 30-40 children under five (5) in foster homes. Ontario driver's license essential. Rural urban area adjoining Toronto. Sound personnel practices. Apply with full particulars to Miss Betty Graham, Executive Director, Children's Aid Society of York County, Newmarket, Ont.

General Duty Nurses, wanted: starting salary $270 per mo. Annual increment $120 to a maximum of $300 per mo. Blue Cross coverage paid by hospital. Room & board available in modern Nurses' Residence, $45 per mo. 28 days vacation. Transportation costs refunded after six(6)-mo. employment. Apply: Director of Nursing, Atikokan General Hospital, Atikokan, Ont.

Registered Nurses (2) $260 per mo. with increments each yr. 3-wk. vacation & sick leave, residence on grounds. Apply to Secretary, Vanguard Union Hospital, Vanguard, Sask.

Staff Nurses for 200-bed general hospital; heart of Los Angeles cultural & educational center. **General Duty:** $320 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Benefits: Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays. 12-dy. sick leave. Uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools. California license obtainable immediately. Apply: Mildred Croddy, R.N. Director of Nurses, Santa Fe Coast Lines Hospital, 610 South St. Louis Street, Los Angeles 23, California.

Wanted-Full time Registered Nurse to live in. Good working conditions & salary $240 mo. less maintenance. Apply to Shelburne District Hospital, Shelburne, Ontario.

For sale. Fine country house suitable for convalescent home. Beautifully situated on Salmon River, adjacent to Agricultural College. Large lawns, shade trees, large lot. Convalescent facilities urgently needed. For pictures and details write, P. D. Hamilton, 46 Main Street, Truro, Nova Scotia.

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The Portage General Hospital, Portage La Prairie, Man.

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Applications are invited for the position of Director of Nurses in 87-bed general hospital.

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For new modern general hospital in Northern Ontario, duties to commence November 1, 1958. 42 adult beds, 11 bassinettes. Must have experience as Director or Assistant Director of Nursing. Salary range $349-$469 monthly. Welfare benefits available. Give details of training, experience, postgraduate studies, & references in letter to

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Apply to:

PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION, ESSONDALE, B.C.

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BRITISH COLUMBIA MENTAL HEALTH SERVICES
ESSONDALE, B.C.

requires

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Director of Nursing, Toronto General Hospital, Toronto 2, Ontario.

Residence, Cook County School of Nursing

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Certificate & badge of the hospital awarded to successful students. Staff nurses' salary paid throughout the year. This work has a special appeal to nurses interested in research & the humanitarian aspect of nursing.

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Please apply to:

Personnel Department
Vancouver General Hospital,
Vancouver 9, British Columbia.

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NURSING SERVICE DEPARTMENT

NAME .....

ADDRESS .....

.....

BIRTHDATE ..... MARITAL STATUS .....

WHERE REGISTERED .....

CLINICAL SERVICE DESIRED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

EDUCATIONAL BACKGROUND

SCHOOL OF NURSING	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL	LOCATION	DATE

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Are invited to enquire re: employment opportunities in a well-staffed new 125-bed hospital in suburban west Toronto. General duty salary range: $240-$290 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST. WESTON, TORONTO 15, ONTARIO. CHerry 4-5551.

LADY MINTO HOSPITAL, COCHRANE, ONTARIO

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1. Supervisors for Medical Dept. & Operating Room. Salaries according to qualifications.
2. Head Nurses for Medical, Pediatrics, Operating Room and Outpatient Departments.
3. General Duty Nurses — all departments. Ontario Registered Nurses' salaries according to the R.N.A.O. schedule.
4. Certified Nursing Assistants — all departments.

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For further information apply to:

THE DIRECTOR OF NURSES, GUELPH GENERAL HOSPITAL, GUELPH, ONT.

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Envelopes should be marked NURAD. Only candidates seriously considered for appointment will receive replies.

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(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

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